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Making Practice-Based Learning Work



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AN OVERVIEW OF THE NATURE OF THE PREPARATION OF PRACTICE EDUCATORS IN FIVE HEALTH CARE DISCIPLINES

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An Educational Development Project funded through
FDTL Phase 4: Project 174/02

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FOREWORD

Making Practice Based Learning Work is the 6th Occasional Paper published by the Higher Education Academy for Health Sciences and Practice Subject Centre (previously LTSN). It is the outcome of the first part of a project financed by the Fund for the Development of Teaching and Learning (FDTL4) and forms an important step in the development of practice-based learning.

For all health professionals a large proportion of learning takes place in hospital and community settings where specialist educators, mentors and trainers help students to put into practice in real life professional situations the theoretical knowledge they have acquired in Higher Education Institutions. There is now a great deal of information about good practices in the various aspects of learning and teaching within these institutions, such as teaching and assessment methods, inter-professional education, e-learning, etc. However there has been much less discussion about practice based learning. Each profession has developed its own methods, but there has been little cross-fertilization of ideas, despite the evident similarities between the professions in training needs. This paper provides a solid stepping stone to advance health professionals along the practice path.

One of the main bottle necks in training more health care professionals, who are greatly needed within the UK and other health services, is the dearth of places with effective support to fulfil the need for practice based learning. This project 'aims to make practitioners more effective at supporting and supervising students in the workplace' and in the first phase has 'identified and documented good practice on how practitioners are prepared for their educational role in Dietetics, Nursing, Occupational Therapy, Physiotherapy and Radiology'. We look forward to the outcome of the next phase in which learning materials for use by professionals across the disciplines will be developed.

Professor Catherine Geissler
Director, HE Academy Centre for Health Sciences and Practice

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GLOSSARY OF TERMS

Practice education

Practice education is the generic term used to describe placement learning in the five professions involved in this project. The Quality Assurance Agency for Higher Education (QAA 2001) uses the terms practice learning and student placement to cover the complete range of placement experiences provided by higher education institutions. Within the National Health Service (NHS) the term clinical placement is used. In the introduction to 'Placements in Focus' (ENB/DoH 2001) a number of phrases are used interchangeably, such as education for practice in health, practice experience and practice placements. Similar terms like work based learning are also common in the literature.

Practice educator

The term Practice Educator is used to describe the identified practitioner in the practice placement who facilitates the student learning face to face on a daily basis and generally has responsibility for the formative and/or summative assessment of competence. Throughout the literature this role is described by a number of terms, including work-based supervisor, mentor, preceptor, practice learning facilitator, clinical tutor and trainer. The potential confusion of these varying descriptions of this role has been recognised (Wilson-Barnett et al 1995).

Lecturer

A variety of descriptions are used to describe HEI lecturers when they are undertaking a practice education support role. To identify them as distinct from practitioners working directly with the student in the practice placement, personnel from the HEI will be referred to as lecturers.

Interprofessional education

The terms multiprofessional, interdisciplinary, interprofessional and cross-professional appear in the health and social care literature. The definition chosen for this project follows closely that set by Centre for the Advancement of Inter-professional Education (CAIPE 1997) and refers to students from two or more health and social care professions learning together whether in an academic or a practice setting.

EXECUTIVE SUMMARY

Practice education is a core element of all educational programmes that prepare health care professionals for academic award and registration to practice. Ensuring quality and effectiveness involves partnership working between Higher Education Institutions (HEI's) and health care providers, social care communities, voluntary and independent sectors offering client care throughout the United Kingdom and Republic of Ireland. Clearly practitioners who support, supervise and assess learners for entry to their respective professions need to be well prepared and supported in their roles as practice educators. However it would appear that the nature of this support and preparation varies across disciplines and that good practice is not easily shared.

With this in mind, the Making Practice Based Learning Work (MPBLW) project aims to make practitioners more effective at supporting and supervising students in the workplace across a range of health care disciplines namely Dietetics, Nursing, Occupational Therapy, Physiotherapy and Radiology. The Department of Employment and Learning (Northern Ireland) and the Higher Education Funding Council for England has funded this collaborative project involving staff from Ulster, Northumbria and Bournemouth Universities. The outcomes for each phase of the project are:

Phase One:

- Identify and document good practice on how practitioners are prepared for their educational role.

Phase Two:

- Develop and evaluate learning materials for use by practitioners across five health care disciplines.
- Make learning materials available in a number of efficient media, e.g. paper, electronic, CD-ROM and web-based.
- Develop a programme applicable to interprofessional and uniprofessional contexts.
- Widen access for a multicultural workforce.

Phase Three

- Embed best educational practice through the establishment of an academic-practitioner network.
- Disseminate a range of materials and processes across the wider academic and health and social care communities.

This executive summary presents an overview of Phase One of the MPBLW project completed between January 2003 and June 2004. A more detailed report follows in the remainder of this occasional paper and the full report can be accessed at the project website. (www.practicebasedlearning.org)

SUMMARY OF THE LITERATURE REVIEW

In keeping with the aims of completing a 'developmental project' rather than systematic research, the literature review is primarily an appraisal of current issues rather than a systematic review of the literature. A key conclusion of this review is that empirical evidence on issues surrounding practice education yields results that arise predominantly from small, local, uni-site and uni-professional data gathered from stakeholders such as students, practice educators and HEI lecturers. In addition there is no evidence of a common preparation route for practice educators from the participant professions.

Moving from the broader context to key issues, the literature review focused on four main areas:

- The nature and effectiveness of practice education
- The role and development of the practice educator
- Interprofessional learning and practice education
- Intercultural issues in practice education

To summarise the first section, conceptual and research literature highlights the variables that affect the quality of practice learning. These include:

- The placement context e.g., patient dependency, nature of the illness, staffing levels, skill mix and personalities.
- Competency and capability of clinical teams e.g. staff are up-to-date and comfortable in the area/speciality of care.
- Communication skills of the Practice Educator (PE) and the interpersonal relationship between the learner and the PE.
- Length of time available for the learner e.g. increasing numbers of learners in placement areas and increasing service demands on the PE.
- Clarity of the purpose and intent of practice learning within the curriculum for learners, PE's and academic staff

Literature related to the preparation for and the role of Practice educators reveals evidence of confusion regarding the role and inconsistency in the level, content and length of preparation courses. Key roles frequently include providing support for learners that will promote confidence, facilitating quality reflection on experiences and in assessing learner competence. In examining preparation for the role, the literature refers mainly to policy and standards documents issued by the registering body.

Moving on to more specific issues, although policy documents advocate the benefits of interprofessional education, the review concluded that evidence for the effectiveness of interprofessional learning is largely anecdotal. It has been found that learners demonstrate signs of identifying with their professional group and also a strong willingness to engage in interprofessional learning. The literature demonstrates that a major hurdle in implementing practice placement interprofessional learning is the formidable practical and organisational obstacles to finding and accessing exemplary collaborative practice placements.

Finally the processes of economic & social globalisation and the increased mobility of labour in health care have resulted in an ethnically and culturally more diverse workforce. This has implications for practice education. Although there is evidence in the literature of work in preparing health care staff to meet the needs of culturally diverse clients, there is very little evidence of projects examining the processes of meeting the needs of practice educators and their students in multicultural workforces. In order to effectively meet the needs of the whole workforce, intercultural competence as a concept and a behaviour or skilled performance needs to be considered when preparing PE's to facilitate effective practice learning within a multicultural workforce.

CASE STUDY METHOD

Case study methodology (Yin 1994) underpinned the choice of data collection methods used to map the current nature of practice education in each of the project disciplines. The remit of the project precluded a formal research study and so the intent of phase 1 was to complete a 'scoping' exercise using the case study method. From this, insights and good practice could be shared across disciplines. Similarities and differences in practice education processes and roles could also be determined in preparation for phase two of the project.

Data collection methods included a survey questionnaire, focus groups and finally analysis of secondary documentary data (see appendices 1 and 2). Heads of Departments of all the participating disciplines within HEI's were targeted, with a request to pass the questionnaire to the most relevant person in the HEI to complete. A total of 193 questionnaires were distributed. The response rate overall was 40.9 % (n=79), Dietetics 46.2% (n=6), Nursing 23.8% (n= 19), Occupational Therapy 67.7 % (n= 21), Physiotherapy 56.8% (n= 21) and Radiography 46.2% (n = 12). Focus groups were conducted at two regional workshops aimed at staff involved in practice education to gather more detailed qualitative data. Four groups of ten participated from the first workshop and two groups of ten at the second. Descriptive statistical analysis of quantitative data was undertaken using SPSS. Qualitative data were analysed using thematic analysis (Polit and Hungler 1995).

Secondary source data was obtained for each of the participant professions through accessing professional and statutory body reports. Case study writers used their experience and networks to access relevant HEI and placement-based policies and documents. These secondary sources were used to provide insight into professional expectations and were compared with current practice through triangulation with both questionnaire and focus group data.

Limitations of the case study approach included a poor response rate to the nursing questionnaire. This may be compensated to some extent by the dominance of nursing within the literature. Intercultural issues were not fully explored due to limitations in the questionnaire design. This will be given specific focus within phase two.

OVERVIEW OF FINDINGS

In keeping with their determination to provide early and wide dissemination of findings, the project team developed a web-site where the case studies have been published in full (www.practicebasedlearning.org). Abstracts from each case study are reproduced within this occasional paper and will not be repeated here. Cross analysis of the five Case Studies highlighted areas of commonality, differences, areas of good practice and perceived topics for further development across all the professional groups.

Commonalities included the following:

- All professions have statutory requirements regarding the nature of work-based learning within the curriculum.
- All students are prepared for the placement experience.
- All professions report to being under-resourced in terms of time, resources and availability of placements.
- All professional groups are required to function within the interprofessional learning and working environment.
- Interprofessional learning is curriculum based rather than work based.
- All practice educators receive a period of development although the content, length and level vary across and within professions and do not necessarily have a statutory agreement.
- No formal career pathway for practice educators exists within the professions.
- All practice educators are involved in formative assessment but to varying degrees in summative assessment.
- Learning needs of practice educators are similar across the professions.

Differences include the following:

- Management, organisation and location of placements within the curriculum and between disciplines.
- Different methods are used to determine placement quality and standards.
- Titles, roles and responsibilities given to the practice educator contrast greatly across the professional groups.
- Criteria for becoming a practice educator vary across the professional groups.
- Recognition, accreditation and standing of the practice educator and method of reward differ within and between professional groups.
- Volume of students; student to practice educator ratios; and models of working with students diverge across groups.
- Supervision and assessment of work based learning by practice educators.
- The nature of the preparation of the practice educator, its length, contents, monitoring or not differs across disciplines.
- Support for practice educators is varied and reported to be insufficient in some instances.
- Divergence in student funding and reimbursement for work based learning.

Several areas of innovative practice emerged which would benefit from wider dissemination and application to other disciplines. Some examples include interprofessional practice educator preparatory programmes, portfolio assessment, regional database of placement availability, e-resources for students and education staff, shared assessment tools across HEI's, variety of supervision models. A number of shared areas of concern also emerged such as the lack of resources for practice education, poor valuing of the practice educator role, shortage of placements and practice educators given increased student numbers. Some of these issues are beyond the scope of the project to consider.

Having analysed the findings, six themes emerged that can be seen to provide a useful platform for future work:

- Learning and Teaching in Practice
- Support for Learning in Practice
- Reflection in Practice
- Assessment in Practice
- Interprofessional Learning in Practice
- Diversity in Practice

CONCLUSIONS AND RECOMMENDATIONS FOR PHASE TWO

The anticipated outcome of phase one was to 'identify and document good practice on how practitioners are prepared for their educational role'. The case study method whilst not comprehensive did yield a sufficiently detailed snapshot of the nature of the preparation of practice educators in five health care disciplines. The exception is that the data related to diversity was inadequate and the project team acknowledge that this area requires particular focus in later phases. However through the vehicle of a case study, a developing practice educator network and the project website, the team has attempted to share good practice in practice education widely as well as highlight issues of concern.

Phase one also highlighted the types of learning resources valued by practitioners involved in practice education. The outcomes of phase two were anticipated to be to:

- Develop and evaluate learning materials for use by practitioners across five health care disciplines.
- Make learning materials available in a number of efficient media, e.g. paper, electronic, CD-ROM and web-based.

- Develop a programme applicable to interprofessional and uniprofessional contexts.
- Widen access for a multicultural workforce.

As the third point illustrates, the project team intended to develop a cross-curricular practice educator preparation programme. However the case study indicates that differing professional standards and requirements would make this difficult to achieve and embed. Instead, responding to data from the case study, phase 2 (June 2004 – May 2005) has involved developing a freely-accessible web-portal of learning materials for use by practice educators in curriculum design and delivery. Working with representatives from across the disciplines, the six themes from phase one have been used to group learning resources and a search facility will be provided. The utility and effectiveness of the learning resources will be evaluated during phase three of the project.

INTRODUCTION

OVERVIEW OF THE CONTEXT FOR THE PROJECT

Practice education is a core element of all educational programmes that prepare health care professionals for academic award and registration to practice. Ensuring quality and effectiveness involves partnership working between Higher Education Institutions (HEI's) and health care providers, social care communities, voluntary and independent sectors, offering client care throughout the United Kingdom and Republic of Ireland. A key facet is this is the role of practitioners who support, supervise and frequently assess learners for entry to their respective professions. Such staff require to be well prepared and supported in their role as supervisors and assessors of practice. However it would appear that the nature of this support and preparation varies across disciplines (NMC 2002a, HPC 2003a, COT 2003, CSP 2003, College of Radiographers 2002). Interprofessional preparation is rare and therefore good practice is not easily shared (Department of Health (DOH) 2001). In addition the nature of this workforce is increasingly diverse, as are the students they support (DOH 2003) and this needs to be taken into account in any preparatory programme.

With these factors in mind, the Making Practice Based Learning Work (MPBLW) project aimed to make practitioners more effective at supporting and supervising students in the workplace across a range of health care disciplines namely Dietetics, Nursing, Occupational Therapy, Physiotherapy and Radiology. This is to be achieved in three phases: in brief phase one involves a case study approach, where the project team sought to scope the five project disciplines in order to describe the nature of practice education and the preparation of those who provide it. From this commonalities and differences could be established with a view to determine the feasibility of common preparation. Phase two aims to identify and develop learning materials for those involved in practice education and finally phase three intends to disseminate and evaluate their impact.

The Department of Employment and Learning (Northern Ireland) and the Higher Education Funding Council for England has funded this collaborative project involving staff from Ulster, Northumbria and Bournemouth Universities. The formal outcomes for each phase therefore are:

Phase One:

- Identify and document good practice on how practitioners are prepared for their

educational role.

Phase Two:

- Develop and evaluate learning materials for use by practitioners across five health care disciplines.
- Make learning materials available in a number of efficient media, e.g. paper, electronic, CD-ROM and web-based.
- Develop a programme applicable to interprofessional and uniprofessional contexts.
- Widen access for a multicultural workforce.

Phase Three

- Embed best educational practice through the establishment of an academic-practitioner network.
- Disseminate a range of materials and processes across the wider academic and health and social care communities.

OVERVIEW OF PAPER

This occasional paper will summarise phase one of the MPBLW project – the case study. This was undertaken between January 2003 and June 2004. The full case study can be accessed at the project website - www.practicebasedlearning.org. It was apparent from an early stage in the project that each discipline used various terms to describe placement learning and those that supervise and assess it. The project team therefore produced a glossary of terms (see page 3). The reader is advised to refer to this to appreciate the meaning of these terms as used in this project.

The case study approach includes three main components:

- Review of the literature around practice education across the five healthcare disciplines
- Data collection including first a survey of all HEI's in England, Ireland, Scotland and Wales involved in provision of practice education for the five identified disciplines; information was sought on the nature of practice education, including educator preparation and support. Secondly, focus groups sessions were conducted in two locations with staff involved in practice education.
- Secondary source data analysis; case study writers used their experience and networks to access relevant HEI and placement-based policies and documents.

Insights were gained into the nature of practice education through triangulation of all sources and this forms the basis of this paper. In the first stage, five discipline-specific

case studies of practice-based education were produced, compiled by professionals from each discipline, recruited by the project team. To ensure consistencies between and within the case studies an agreed format was used which considers the nature of the disciplines involved, the context of the current functions, the preparation of the practice educator and areas of good practice and innovation. From these, comparisons were made and conclusions drawn to form the overall case study.

It is important to state that the remit of the project precluded a formal research study and that the intent of phase one was to complete a 'scoping' exercise using the case study method. It was anticipated that from this a snapshot of practice education across disciplines would be gained, meeting the key outcome of this phase. In addition similarities and differences in practice education processes and roles emerged as well as insights into the need and possible use of learning resources. This set the scene for the next phase of the project.

Moving on to the structure of the paper, a literature review follows to provide the reader with some insight into some of the key issues in practice education and educator preparation. Then the data collection phase will be explained, followed by an overview of the findings, which involves an exploration of practice education 'on-the-ground' via each discipline-specific case study. Finally conclusions are drawn from the analysis of the five case studies and some recommendations made to inform subsequent phases of the project.

LITERATURE REVIEW

INTRODUCTION AND SCOPE

In health and social care professions learning in practice placements is an essential part of education programmes that prepare students for professional registration and academic award. To safeguard the public, it is vital that students achieve professional competence in order to be registered to perform the role of the skilled practitioner (QAA 2001, HPC 2003, NMC 2002, An Bord Altranais 2000). Expert practitioners, as practice educators, teach and assess students and are therefore recognised to have the key role in practice learning.

However, although experts in their particular practice fields, the assumption that all practitioners are also expert practice educators cannot be made. There is a continuing debate on the skills, knowledge and expertise needed to facilitate practice learning. Preparation for the role with ongoing development and continuous monitoring of the quality of practice learning facilitation by practitioners is a key issue for all health care professions. For health care service and placement providers in the UK, tensions also exist between the need to provide a quality and cost-effective service to clients and the demands made on them in teaching and assessing increasing numbers of health care learners.

The aim of this literature review is to provide a brief critical overview of the issues involved in supporting practice learning. In keeping with the aims of completing a 'developmental project' rather than systematic research, it is primarily an appraisal of current issues rather than a systematic review of the literature. Sources used for this appraisal include electronic databases, library searches, government and professional body publications. The time frame focuses on the last ten years with occasional reference to earlier key policy documents or published work that has influenced change within that time frame.

Literature sources predominantly reflect the current situation in the UK and the Republic of Ireland though some cross comparisons are made with developments elsewhere in the world. Although practice learning occurs throughout a professional's career, the literature selected for this review primarily concentrates on pre-registration practice education.

Research and development in the arena of practice learning is uneven across the particular health professions involved in this project. This review aims to provide a more

generic overview of the literature using resources from general educational literature as well as those from the specific professions involved in the project. The volume of citations does reflect the amount of conceptual and empirical work already completed by particular professions (e.g. nursing). However, an attempt is made to ensure balance in any conclusions drawn from the literature.

The empirical evidence cited is generally based on uni-professional experience where studies are small and localised. Most studies include only one educational site and often students of one profession. This data whilst valuable in terms of the rich insight it offers, is not, however, generalisable. Nonetheless, this does not make these findings irrelevant, as research users will be able to judge transferability of findings to other settings. However, the lack of large scale, countrywide or international comparative studies is a limiting factor in drawing widely applicable conclusions. Other disciplines, notably teaching (Jowett & Stead 1994, Woodd 1997) and social work (Dick et al 2002, Torkington et al 2003) have completed studies and where their findings have been considered applicable they have also been included.

The literature overview moves from a broad perspective of practice education and the practice educator role, to consider the more specific and topical issues of interprofessional education and the impact of diversity on practice education. The review is organised and presented therefore under four headings with a number of sub-sections:

- The nature and effectiveness of practice education
- The role and development of the practice educator
- Interprofessional learning and practice education
- Intercultural issues in practice education

Throughout the review, at the end of each sub-section, summary points arising from interpreting the literature have been included; these are also summarised in the final section.

THE NATURE AND EFFECTIVENESS OF PRACTICE EDUCATION

For the purposes of this review, the term 'practice education' subsumes 'practice learning' and 'practice teaching'. 'Effectiveness' is used here to demarcate quality issues related to the provision of practice learning.

The scope of the literature in this area covers issues around the following sub-divisions:

- The nature of learning through, for and at work
- The role and needs of the learner
- Organisational issues in practice learning

THE NATURE OF LEARNING THROUGH, FOR AND AT WORK

All learners involved in completing a programme of study for a health care professional qualification are required to spend a proportion of their programme time, often up to 50%, learning in a practice setting (Chartered Society of Physiotherapy 2003, NMC 2002, College of Occupational Therapists 2003, College of Radiographers 2003). It is important therefore to examine the issues surrounding the nature of practice learning.

A core concept related to practice learning has been adopted by the majority of health care professions over the past two decades. Professions have championed the central premises of 'reflective' practice with particular reference to the seminal work of Schon (1983, 1987). In a recent publication, Redmond (2004), a social worker, refers to the citation of Schon's work by the majority of health care professional groups, including medicine (Ming Tang 1998; Tate and Sills 2004). Nursing in particular has a history of having adopted Schon's work as a core element of facilitating learning in and from practice experience since the late 1980s (Clarke 1986, Jarvis 1992, Palmer et al 1994, Stockhausen 1994, Burnard 1995, Greenwood 1998, Durgahee 1998, Mallik 1998, Graham et al 1998).

Schon based his theories and their application on earlier work by Dewey (1916; 1933) and along with Argyris (Argyris & Schon 1978; 1996) has had a major influence on the development of a body of conceptual and empirical work around the nature of practice learning. Dewey (1933) recognised the social nature of learning and the importance of the continuity of experience. Concrete experiences in the practice setting can be reflected upon leading to new insights and application of new learning (Kolb 1984). However, learners need to engage with the experience, deconstructing and reconstructing it in order to learn from it and build their own unique body of knowledge. It should be acknowledged that, to promote effective learning, the learner needs support and guidance from the practice educator in undertaking this process.

Schon's ideas on reflective practice include an element where time and space is needed for the skilled practitioner and the learner to review and appreciate the interconnections between theory, intuition and practice. The practitioner working alongside a learner needs to have good coaching skills in order to make the implicit, often tacit, knowledge embedded in skilled practice, explicit for the learner (Schon 1983). Blackwell et al (2001) reported that it has been repeatedly suggested that the quality of the student's reflection is fundamental to the quality of learning. Dutton (2003) and Dewar & Walker (1999) include the encouragement of the student's reflective process in the practice educator's role function.

It could be argued that, for effective practice learning, using a reflective practice model, practice educators should have the knowledge and skills to coach learners through triggering reflective learning periods on-the-job where there is a shared knowledge of the context and events (Eraut 2004).

A claim for the effectiveness of the 'reflection' model in the arena of practice learning has included reference to its ability to integrate theory and practice. The design of 'tools' to use to facilitate reflection has proliferated in the literature with the most common being that of the reflective account written up in a learning log or 'diary' (Moon 1999). Promotion of structural frameworks for these written accounts (Johns 1995, Boud et al 1985, Gibbs 1988) has provided a way for academic institutions to assess and accredit practice learning (Mallik 1998, Bournemouth University 2001).

The more recent developments in the accreditation of work-based learning through the examination and grading of portfolio learning has incorporated elements of reflective learning as well as judgements on competence to practice (Sumsion & Fleet 1996, Challis et al 1997, Taylor et al 1999, MacMullen et al 2003). Making sense of the relationship between theory learned in the classroom and their practice learning experiences is important to learners. The practice educator needs to assist students in reflecting on and recording their experiences, encouraging them to relate those experiences to theory already learned in the classroom. Spouse (1996) refers to this as the 'sense making' role of the mentor.

Summary point:

- *In order to integrate theory and practice, practice educators need knowledge and skills in promoting reflective learning; have ability and authority to facilitate time and place for the learner to record their learning; and have insight into the knowledge provided within the academic curriculum*

THE ROLE AND NEEDS OF THE LEARNER

In facilitating learning in a practice environment, the student is viewed as an active participant. The model of 'cognitive apprenticeship' (Browns, Collins & Duguid 1989, Taylor and Dean Care 1999) reflects the current role of learners in health care placements in the UK and Ireland. Although supernumerary, they are active participants and continue to learn through the apprenticeship mode of observing, being coached by an expert and practicing in the authentic context. They not only gain explicit knowledge and skills in communication, psychomotor and clinical decision making but also need to develop the processes of integrating the knowledge with the conditions under which that knowledge applies and the culture in which that knowledge is used. A key skill required of students is that they learn to integrate into the culture and 'communities of practice' (Lave and Wenger 1991, Wenger 1998, Spouse 1998, Eraut 2003).

Professional socialisation of health care students has been the subject of considerable debate in the literature during the mid to latter part of the 20th century. Key studies in this area include the socialisation of medical students in the USA (Merton et al 1957, Becker et al 1961) and Melia's work on the socialization of nursing students (Melia 1987). The worldview perpetuated by these earlier studies considers students to be passive in the socialisation process. Whilst this has since been challenged (Clouder 2003), evidence continues to be presented by researchers of the power of socialisation processes, particularly in the practice setting, to be able to transform students to meet the 'ideal' expectations of the profession (Du Toit 1995, Howkins & Ewens 1999).

Clouder (2003), in her longitudinal study of occupational therapy students, argues that, although students learn to 'play the game' in the practice setting they are self aware and will retain their own personal agency, learning to find a route through the professional socialisation process. Clouder's (2003) learners highlighted their need to get 'things right'

and to know that they were getting it right; for example performance has to be validated by designated practice educators.

Practice educators, who are in an obvious position of power vis-à-vis the learner, need to be aware not only of their performance as role models (Bandura 1977) but should also be sensitive to their influence on the professional socialisation of the learner.

The apprenticeship model generally assumes a one to one partnership in learning between the 'master' and the 'apprentice' (Eraut 2003). Individual learners have differing intrinsic needs as well as the demands for varying levels of competence as they complete their learning programmes. Successful attainment of predetermined and prescribed competencies is required by registration bodies (HPC 2003, NMC 2002, An Bord Altranais 2000). Learners need to achieve the prescribed competencies and rely on the practice educator to guide their learning, assess their competence and thus effectively act as 'gate keepers' to the profession (Woodd 1997; Duffy, 2004).

For effective practice education, learners also need time and attention from practice educators (Spouse, 1996). Turner (2001) describes the pressures on clinical staff and the impact of high patient turnover resulting in little time to devote to the supervision of students; an issue that is exacerbated by the increasing demands on the available practice placements (Bennett 2003).

Summary point:

- *It is argued that to be effective in meeting learner needs, the practice educator has to have time and considerable educational skills to ensure recognition of the stage of learning or skill acquisition that needs to be facilitated and/or assessed at the appropriate time for the learner.*

ORGANISATIONAL ISSUES IN PRACTICE LEARNING

In reviewing the length of time spent and the sequencing of practice learning within the curriculum, Blackwell et al (2001) and Torkington et al (2003) describe a lack of quantitative evidence about the impact of different placement experiences on different groups of learners. Using a variety of data collection tools such as visits, phone interviews and literature reviews, Blackwell et al (2001) consider good practices in work experience

placements for teachers. They concluded that for work experience to be effective, it needed to be purposeful and that all stakeholders i.e. students, employers, academic staff and experienced employees should have the ability to articulate what has been learnt.

It is interesting to compare the Australian model for supporting practice learning in nursing. Short, well-planned placements are the norm. Students are prepared through extensive skills laboratory practice 'on campus'; they are briefed and de-briefed during each placement episode by a Clinical Facilitator who supports a group of up to eight students. Although 'buddied' with a service practitioner, their overall progress is monitored and assessed by the Clinical Facilitator (Department of Education, Science & Training 2002, Australian Universities Teaching Committee 2002, Mallik & Aylott 2003). Another pattern is that proposed for the new nursing four year graduate programmes in the ROI (first intake September 2003); third year students will return to the paid workforce for a full salaried 'apprenticeship year' (Government of Ireland 1998).

With the annual commissioning of increased student numbers from all the health care professions in the UK (DoH 2000) and the consequent impact on providing sufficient and good quality practice placement areas, the reliance on skills laboratory learning is also a growing trend in the UK. The current emphasis is being placed on interprofessional learning using quite sophisticated simulation models and 'actors' to develop and test not only practical clinical skills but also communication, clinical reasoning and decision making skills (Edwards et al 1995, Nicol & Glen 1999, Ladyschewsky et al 2000, Ker et al 2003, Peteani 2004). It could be argued that HEI's need to monitor and evaluate these developments through future comparative studies.

Individual learner support is the approach reported in the majority of literature on practice learning and reference to the apprenticeship model in the previous section alludes to a 1:1 relationship where one learner works alongside and learns from one 'master'. As stated above, there are tensions in providing sufficient and effective practice learning placements for the increasing numbers of health care students. This has stimulated debate about the continuance of the dominant 1:1 model in practice learning.

Comparisons across professions and internationally reveal alternative models that include: learner allocation to consultant teams (medicine); allocation of 1:2 in physiotherapy; allocation of one Clinical Learning Facilitator to eight learners (nursing in Australia) (Mallik

1998, Mallik & Aylott 2003, Baldry Currens 2000, 2003). In the UK, although there may be pressure, particularly in nursing, to be responsible for a number of different learners at any one time, QAA (2001) and professional standards demand that practice educators facilitate learning and undertake practice assessment on a 1:1 basis.

The continued exploration and critical appraisal of the effectiveness of different sequencing and patterns of placements along with proposed alternatives to the 1:1 model of practice educator support for health professions may provide innovative models for practice learning effectiveness in the future.

Structured organisational support or 'brokerage' for the 'coal face' practice educator is usually undertaken by an appointed named individual either employed by the Health Care Institution (HCI) or by the Higher Education Institution (HEI). Historically, in nursing and the therapy professions, the 'link lecturer' role has been the subject of scrutiny and generally considered ineffective (Cohn & Frum 1988, Neville and French 1991, Neville & Crossley 1993, Cross 1995, Clifford 1996, Day et al 1998, Aston et al 2000, Mallik & Aston 2003).

For nursing in particular, a proliferation of 'new' support roles has been created following the recommendations of the Peach Report, with a consequent strengthening of partnerships between the HEI's and the HCI's (UKCC 1999, DoH 1999). Various titles have been given to these roles by the different professions (see Case Studies). Post holders generally provide a co-ordination, advisory, and supportive role for both the learners and the practice educators. They liaise and negotiate between the HEI and the HCI providing placements for the learner, problem solving any issues and advising on placement capacity and quality.

Eraut (2003) is critical of the effectiveness of these roles in relation to the direct learning experiences of students, arguing that they tend to be allocated to senior staff that have relatively little contact with the learner. However, early evaluation studies in Ireland and the UK indicate that they have value particularly in relation to their key stated functions (Department of Health and Children 2001, Clarke et al 2003, Ellis & Hogard 2003). Overall, it could be argued that because learning now takes place in a practice environment that is increasingly complex and challenging for all health care practitioners, that commitment to developing a learning organisation and creating a supportive learning environment by whatever means is acceptable.

Collaborative partnership systems between HEI's and health and placement providers that sustain and support the role and function of practice educators should be retained and continuously evaluated for their effectiveness. A supportive learning 'environment' is an area alluded to in the literature with various interpretations of how it is created and sustained. A focus on key personnel dominates the nursing literature particularly in relation to placements in acute hospital wards. Past evidence, at a time when the learner was an integral part of the nursing workforce, demonstrates that the role of the clinical leader (ward sister) was considered most influential to the development of an effective learning environment (Ogier 1982, Orton 1981, Fretwell 1982).

Clouder's (2003) recent study on the socialisation of occupational therapy students is more relevant today for all health care learners. Her evidence testifies to a diffuse source of influence with the key individual being the allocated practice educator. Increasingly the policy agenda to foster inter-professional learning promotes a team approach to practice learning. This, coupled with an increasing focus on encouraging the creation of a learning organisation (DoH 2000a, DoH 2001) presents a case for multiple influences on creating an effective practice learning environment.

Exploration of the concept and operationalisation of team and organisational learning and their relationship to each other and individual learning is still relatively new. It is argued that service quality and team performance is improved as a consequence of team and organisational learning (Chan 2001; 2003). The conceptualisation of organisational learning by Goh and Richards (1997) provides possible benchmarks in five areas that would allow any organisation to assess its commitment to a supportive learning environment. These areas include; clarity of purpose and mission; leadership commitment and empowerment; transfer of knowledge; experimentation and rewards; teamwork and group problem solving. Although the nursing profession in particular audits the quality of practice placements (ENB/DOH 2001), the focus is on examining each individual area's learning environment. Included in these audits is a summary evaluation of the quality of practice educator support. However there is often no reference to team learning or the influence of the organisation's commitment to supporting practice learning.

Summary point:

- *In auditing the learning environment and in providing any learning resources to support practice educators, the relative impact of team and organisational learning needs to be considered.*

Having considered issues pertinent to the environment for practice education, the literature on the role of the practice educator working within this context will now be explored.

THE ROLE AND DEVELOPMENT OF THE EFFECTIVE PRACTICE EDUCATOR

The term 'practice educator' has been specifically selected as the most suitable generic term for use within this interprofessional project (see Glossary). However, the literature cited in this section does refer to the specific terms used by the different professions. These most commonly include the words 'mentor' (nursing and teaching), 'clinical supervisor' or 'clinical tutor'.

It is worth noting that the majority of relevant literature on the role of the practice educator is nursing based and there is a relative paucity of publications from the other disciplines involved in this project. The nursing literature is supplemented by publications from midwifery, social work and those in higher education involved in teacher education.

Andrews and Wallis (1999) reviewing the literature on mentorship in nursing concluded that there was confusion both in regard to the concept of mentorship and the role of the mentor. This difficulty with role definition appears to be a feature of other roles relating to placement learning. A national evaluation of the role of the clinical placement co-ordinator in the Republic of Ireland (Department of Health and Children 2001) found that 70% of respondents stated that the role was inadequately defined. Jowett and Stead (1994), in considering the mentoring of teaching students, conclude that there is a lack of a satisfactory understanding of what exactly is involved in mentorship.

Despite difficulties in defining roles, when analysing the activities expected from the practice educator a more coherent picture emerges. Woodd (1997) describes the

placement supervision process as being about developing the student's learning from practice. The ENB/DoH (2001;2001a) describe the two key responsibilities within the role to be to assume accountability for the student's learning in the practice setting and to undertake the formative and summative assessment of student learning in practice.

This section is presented under the following three sub sections:

- Facilitating practice learning
- Undertaking the assessor role
- Preparation for the practice educator role

FACILITATING PRACTICE LEARNING

In undertaking the practice educator role, Spouse (1996) proposes a quite detailed list of activities that are necessary to be effective. These include: befriending; planning; collaborating; coaching; and sense-making. Similar to Spouse, Evans (1999) describes the main functions of the practice educator to be enabling, teaching and organising placement opportunities. The two main elements of 'enabling' are described as being supportive and empowering of the student. The significance of the supportive element of the role of the practice educator is the need for learners to believe they are capable and that their engagement with learning tasks is related to a belief in success (Brennan & Little 1996). This view is also highlighted in a small study by Sloan (1999), who used a convenience sample from six adult mental health teams. Of the 32 good qualities described by respondents, the highest rated quality was that the supervisor made them feel comfortable enough to discuss their own limitations and had the ability to develop supportive relationships.

The relationship between the student and the practice educator is described in the literature as being of key importance (Dick et al 2002), with the reminder that in professional training, students learn not only from absorbing 'content' but also from their learning experience (Ward 1999). In a literature review on effective supervision in practice settings for medical students, Kilminster and Jolly (2000) comment on the significance of interpersonal exchanges within supervision roles.

Andrews and Wallis (1999) note that a common theme in the mentoring literature is the significance of the personal characteristics of the mentor. However, in an earlier study,

Jacka and Lewin (1987, cited by Brown 2000) revealed that the reality of student nurse clinical placement was complicated by many variables; this did include personalities involved, but also patient dependency, patient illness, skill mix and clinical credibility. Brown (2000) considered 238 end of placement reports from 3 groups of students and similar to Jacka and Lewin (1987), concluded that there were a number of complex variables involved.

The implications for learning in a practice area if staff are not up-to-date and competent, are obvious and therefore practice proficiency is an important element in supporting effective practice learning. Although good teaching and interpersonal skills are necessary for effective supervision, Kilminster and Jolly (2000), also noted the importance of clinical competence and knowledge. The ENB/DoH (2001) refer to the importance of ensuring that those with practical and recent experience of their professions teach health care students. In support of this argument, they recommended that practitioners have a minimum of one-year full-time post registration experience prior to taking on the practice educator role. Although practice educator skills are transferable, it is suggested that those who transfer to a new area of practice need time to re-develop and demonstrate sound professional knowledge and skills.

Summary point:

- *An effective practice educator needs good communication and interpersonal skills as well as practice proficiency and the ability to facilitate learning opportunities*

UNDERTAKING THE ASSESSOR ROLE

Going back to the second main function cited by the ENB/DoH (2001), that of practice assessment, the literature also raises issues relating to valid and reliable assessment of students by practice educators (Brown 2000). Arguments are proposed both for and against the use of clearly defined learning outcomes (Brennan & Little 1996). Chambers (1998), reviewing the practice assessment literature reinforces the responsibility of the practice educator for this role, but indicates that individuals may have different perceptions of competence. Practice educators are expected to make valid and reliable assessments of learners' competence to practice and to validate any written evidence of that competence contained within a portfolio of learning (Norman et al 2002, Watson et al 2002). Where practice educators are supported through joint assessment strategies with

the HEI, there may be no problems. There is evidence however, particularly in nursing, that shared assessments do not happen (Wilson-Barnett et al 1995, Phillips et al 2000).

More importantly further evidence from nursing, midwifery and social work studies indicate that a considerable percentage of practice educators have difficulty in taking responsibility for 'failing' students (Burgess et al 1998, Fraser et al 1998, Watson & Harris 1999, Sharp 2000, Duffy 2004). As they are the 'gate keepers' to the profession and as such have a key role in public protection, there is an urgent need to ensure that all practice educators are adequately prepared to confidently assess students.

Reasons cited for this 'failure to fail' students include: lack of understanding of the assessment documentation; students not on placement for long enough to gain competence; insufficient time to work with the student to make judgements; fear of the perceived consequences for the student; a sense of personal failure; lack of support in the decision to 'fail' from lecturers (Ilott 1996, Sharp 2000, Phillips et al 2000, Duffy & Watson 2001, Dolan 2003, Duffy 2004). Duffy (2004), in her study of nurses in Scotland, found that all mentors interviewed stated that the topic of 'failing' students was not dealt with in their mentor preparation programmes. She goes on to state that :

'The literature supports the view that mentors feel ill prepared for their role (Wilson-Barnett et al 1995, May et al 1997) and there is often a lack of coherent support for mentors from lecturers (Cahill 1997). Given that mentors are ill prepared for their role in failing students it is recommended that mentorship programmes address the issue of accountability. It should also be recognised that the issue of responsibility in relation to 'failing to fail' lies not only with individual mentors, but also with individual lecturers'.

(Duffy, 2004 p 71)

Summary points:

- *In order to value and formally recognise the importance of the practice educator role in facilitating learning and assessing practice competencies within health care curricula, there is a need to develop clearly defined educational competencies in practice educators to ensure effective practice learning.*
- *To guarantee public protection, practice educator preparation courses should include the issues of accountability inherent in dealing with the 'failing' student*

ROLE PREPARATION

A government briefing paper reported that a significant amount of practice education is conducted on an ad hoc basis (Damodaran et al 2002). The Department of Health (DoH, 2000) recommended that education and training needs to be responsive to the skills and competencies required for health care delivery, an argument that is equally applicable to practice educator preparation. The assumption cannot be made that the experienced skilled practitioner will automatically effectively fulfil the practice educator role. From the issues outlined in this overview of the literature and the individual case studies presented in this project, it is evident that preparation for the role is essential.

The ENB/DoH (2001) provided a framework of guidance for nursing for the preparation of mentors and teachers; the NMC (2002a) published standards for the preparation of teachers of nursing and midwifery. The NMC (2002a) set required standards based on the following learning outcomes:

- communication and working relationships
- facilitation of learning
- assessment
- role modelling
- creating an environment for learning
- improving practice, knowledge base and course development

These standards, although with an obvious nursing bias, have been considered as a base for other health related professions. NMC (2002a) requirements and a recent discussion document (NMC 2004) suggest a developmental approach to preparing practice educators. Titles might reflect a progressive acquisition of practice educator skills and experience to follow a pattern from 'associate mentor' → 'mentor' → 'practice teacher' - → 'qualified teacher'

There is no specific academic level for 'mentor' preparation courses and a flexible approach to programme provision is advocated, with preparation both in practice and academic environments. The consultation document states that the change in status of the mentor standard enables NMC Visitors (Quality Assurance inspectors) in England and agents in Northern Ireland, Scotland and Wales to require evidence that mentorship outcomes have been met by those undertaking the practice educator role.

The discipline-specific case studies provide evidence of inconsistency in the length and level of preparation courses required and provided for practice educators across the health care sector. This is not solely between professions but also within them. In addition, in relation to nursing, Andrews and Wallis (1999) indicate that in some areas with a shortage of mentors and an increasing demand for practice placements, short preparation programmes are provided. They question the value of these programmes.

Wilson-Barnett et al (1995) & Phillips et al (2000) demonstrate that mentors are ill-prepared and that preparation varies from area to area. Studies, which considered the preparation of clinical supervisors mentoring post-registration students, have also illustrated the importance of preparation for the role and the possibility of developing methods that allow for the measurement of the impact of clinical supervision (Milne & James 2002, Severinsson & Borgenhammer 1997). Overall, the discipline-specific case studies indicate that there is a lack of literature on the content and outcome effectiveness of courses designed to prepare practice educators for their roles.

Summary point:

- ◆ *Provision of courses and/or learning materials to develop and support the practice educator role need to be reviewed and evaluated for outcome effectiveness*

Having considered some broad issues in the nature of practice education and preparation for the practice educators role, two key drivers in practice education will now be explored: first interprofessional learning and then diversity.

INTERPROFESSIONAL LEARNING AND PRACTICE EDUCATION

The current health and social care policy agenda in the UK recommends a refocusing on education and training arrangements, which are genuinely interprofessional (DoH 2001). As the operationalisation of the policy agenda on Interprofessional Education (IPE) is still in a relatively early stage of its implementation, this section provides an overview to include definition, developments and evaluations to date. IPE subsumes the terms interprofessional learning and teaching.

Interprofessional education was originally conceived as a means to overcome ignorance and prejudice among health and social care professions: the aim being that by learning together the professions would work more effectively together and thereby improve the quality of care for patients (DoH 2001). The much-quoted definition by CAIPE states:

‘that interprofessional education occurs when two or more professions learn from and about each other to improve collaboration and the quality of care. It is seen as a subset of multiprofessional education during which professions learn side by side for whatever reason’.

(CAIPE 1997)

The perceived benefits of IPE are an increased ability to share knowledge and skills, enhanced personal confidence and professional development, greater respect between professions and encouragement of reflective practice (Wood 2001). However, according to Barr:

‘a balance needs to be struck between instilling common curricula and developing interactive learning, so that the professions not only secure a common foundation for practice, but also appreciate the distinctive contribution that each brings to collaborative practice’.

(Barr, 2000 p3)

Supporting Barr’s need to retain a balanced argument, Hind et al (2003) considered the interprofessional perceptions of health care students. A total of 933 questionnaires were sent to first year students in medicine, nursing, dietetics, pharmacy and physiotherapy in one university (response rate 55%). Results demonstrated that even at this early stage in their programmes, students not only showed signs of identifying with their professional group, but also a strong willingness to engage in interprofessional learning.

However, in commenting on evidence from an earlier study commissioned by the English

National Board for Nursing and Midwifery and Health Visiting (Miller et al 1999), concluded that common curricula were established to reduce duplication in educational programmes, as opposed to utilizing and valuing professional differences, to inform collaborative working (Miller et al 1999).

As many of the 'new' IPE developments in pre-registration curricula are currently being planned and implemented there is still a relative paucity of evidence on the processes and outcome effectiveness of IPE in the UK. Much of the work to track developments have been completed by the Centre for the Advancement of Interprofessional Education (CAIPE) and is published on their web site (www.caipe.org.uk).

A systematic review of the literature (mainly pre-2000) by Freeth et al (2002) indicates that most of the evaluations of IPE published are from studies undertaken related to post registration education and training in the workplace and are often linked to patient care improvement initiatives. The majority of good quality evaluation studies were undertaken in North America and fewer than 30% included pre-registration students. Freeth et al (2002) report that the outcomes measured in most studies focused on; learners' reactions; changes in their attitudes and perceptions; individual behavioural, knowledge or skill changes; organisational changes; and benefits to client care.

In the UK, employers do engage in providing IPE at postgraduate level and evidence does indicate that services are improved as a result of these initiatives (Tope 1999 and 2001). In concluding their review, the research team advocated that, in commissioning future studies in the UK, a smaller number of comprehensive evaluations of different types of IPE with a focus on prospective studies with longer follow up periods were essential.

Of perhaps more relevance to the aims of this project is the publication of a case study report, commissioned by the DoH, of current IPE initiatives being conducted in the UK (Barr & Goose 2002). The criteria for inclusion were that the programmes

'included common learning in all or part of the curriculum; involved three or more health and social care professions; involved the NHS, higher education and, where appropriate, other agencies as partners; addressed current NHS developments; was subject to robust evaluation'.

(Barr & Goosey, 2002 p 2)

Fifteen case studies are presented with eight of these focused on pre-registration IPE. The report acknowledges that all of these case studies pre-date the government initiatives

to include IPE in foundation programmes (DoH 2000); however data from the Southampton University pilot for the 'New Generation Project Curriculum' due to commence in September 2003 was included. Case studies reported on both HEI organised courses and initiatives in practice based learning.

A practice learning example included the IPE training ward set up by St. Bartholomew's Hospital and City University in London for medical, nursing, physiotherapy and occupational therapy pre-registration students (Reeves and Freeth 2002). Barr (2001) does acknowledge the constraints in providing practice placements where learners are exposed to examples of good collaborative practice. A concurrent issue is the feasibility of including interactive learning in small groups for large numbers of pre-registration students within current budgetary constraints (Cook et al 2001). Although Barr (2001) recommends peer group learning as a possible solution, he acknowledges that such a model would need to be preceded by teacher-led group learning. Practice educators would be well placed to facilitate these processes. Other barriers in shared placement learning include the practical difficulties that arise from course organization, clinical shifts and classroom timetable incompatibilities (Leaviss 2000, Cook et al 2001, Morison et al 2003, Torkington et al 2003).

Of particular interest in the development of practice educators is the report of a four modular programme provided by Oxford Brookes University to prepare practitioners to teach, supervise and assess students in practice (Barr and Goosey 2002). This course was designed primarily to meet the professional award requirements for nurses and social workers. However, occupational therapists, physiotherapists and paramedics also accessed it. Students were encouraged to exchange information and develop ideas on how to facilitate the learning of students from professions other than their own (Barr & Goosey 2002). Although there is anecdotal evidence that many HEIs are now developing interprofessional post-graduate teacher education programmes, Barr (2001) argues that more needs to be done. There is a need to ensure that post-graduate programmes for newly appointed teachers in health and social care introduce students to the rationale for IPE and to encourage the design, delivery and evaluation of new initiatives in IPE.

Summary point:

- *Opportunities for Interprofessional learning in the practice setting are still being developed. Practice educators potentially play a key role in the organisation and*

facilitation of interprofessional practice based learning. Preparation programmes for practice educators need to include specific learning to fulfil this role.

INTERCULTURAL ISSUES IN PRACTICE EDUCATION

For the purposes of this project intercultural is taken to mean people from different cultures working alongside one another, engaged in a common endeavour. The context of this review is practice education of qualified practitioners as well as those preparing for professional registration.

The scope of the literature in this area covers issues around the following sub-divisions:

- The context for intercultural healthcare workforces
- Intercultural mentorship
- The nature of culture and difference in practice learning
- Implications for practice-based learning in health care

THE CONTEXT FOR INTERCULTURAL HEALTHCARE WORKFORCES

The UK is a multicultural society and the composition of healthcare workers reflects this. The promotion of cultural diversity throughout health care organisations and across health care professions is a key policy area (DoH 2003) for equal opportunity employment reasons as well as to address concerns that health care is insufficiently culturally sensitive. Stereotyping and prejudice may result from exposure to different cultures. MacLachlan (1997) writes that their role as practitioners of health care does not make professionals immune from such reactions. Awareness of this should be fundamental to practitioner education as a key clinical skill. However, Gerrish (1997) writing about nursing reported 'a lack of cultural awareness in British healthcare'. Similar issues are raised in relation to dietetics education (Suarez & Shanklin 2002) and occupational therapy (Black 2002).

An additional significant factor in this debate relates to the globalisation of health care workforces. Migration is certainly not a new phenomenon. What is new is the extent of migration of healthcare professionals, as travel becomes easier and educational frameworks become more consistent and interchangeable. Much has been written about

nurse migration mainly because this is the largest professional group in healthcare. However, the issues raised by migration can be applied to most health professions. Staff shortfalls exist currently and are predicted in a range of other health care professions in the western world, for example in radiology (Reiner et al 2002) and medicine (Dowie & Langman 1999).

Focusing then on the nursing literature, as a result of the shortage of registered nurses in the western world, there has been an unprecedented increase in international recruitment in developed countries (Kline 2003, Buchan 2001). The processes of economic globalisation and the increased mobility of labour in health care have resulted in a workforce which appears ethnically and culturally more diverse than in previous decades when globalisation and migration were less prominent. In the UK for example, more than 30,000 new non-UK nurses have registered in the UK since 2000, with the number growing each year (RCN 2003). This trend is replicated in other professions in health and social care.

Growing demands for skilled nurses has motivated international recruitment by developed countries. However, their availability is rapidly reducing, which has been the result of an ageing nursing workforce while demographics and the opportunity for different career choices has reduced the numbers of student entries to the profession. The 'import' of nurses is seen as a quick solution to shortages at the same time as the problem of nurse shortages is 'exported' elsewhere (Buchan 2001, Kingma 2001). Kingma (2001) reports that nurse migration is motivated by the search for professional development, better quality of life and concerns for personal safety in areas of political instability.

The NHS has relied on overseas nurses at various points during its lifetime. Nurses from the Caribbean migrated to the UK in the 1950's and 1960's. Irish women were the second major group of migrant nurses, though this trend has been reversed in recent years (Buchan and Edwards 2000). Today the migration of nurses to the UK occurs within the context of regulatory structures governing migration and career entry. Professional regulation through the Nursing and Midwifery Council, EU treaties on the free movement of labour across the European Community, and government guidance on international nursing recruitment (DoH 2001a, RCN 2002) are shaping the way nurses are recruited internationally.

However, these efforts do not address the issues that overseas nurses who are recruited to the UK face. Some research is beginning to emerge concerning the experience of internationally recruited nurses (IRN's). Allan & Larsen (2003) explored the motivations and experiences of IRN's working in the UK. 67 participated in focus groups across 3 sites in England and Wales. It was found that the experience of coming to work in the UK was personally demanding. They had to cope with different working practices, integrate into nursing teams and some experienced a severe drop in status. Whilst not always the case, some were faced with hostile and unsupportive colleagues. Although adaptation programmes go some way to inducting international recruits to UK health care culture, induction programmes are yet to be established, which aim to provide UK nurses who work with international recruits with greater understanding and capacity to work with professional and social differences (Allan and Larsen 2003).

Gerrish & Griffith (2004) report on selected findings of an evaluation of an adaptation programme for overseas Registered Nurses. Data was collected from various stakeholders, including 17 overseas nurses plus mentors and managers involved in the adaptation programme, concerning their perception of the success of the programme using focus groups and in-depth interviews. Five meanings of success were identified: the achievement of professional registration, 'fitness for practice', reducing nurse vacancy factor, retention and finally promotion of an organisational culture that values diversity. One significant factor identified by the study to influence success was whether there was a positive interpersonal relationship between the overseas nurse and mentor. The study also found that whilst sharing of expertise was evident, like Allan & Larsen (2003) some experienced hostility from a minority of British nurses. Both these studies indicate that whilst IRN's bring valuable nursing experience to the UK, their ability to function to their potential is in part determined by an acceptance of the value of cultural diversity by the individual and the employing organisation.

Summary points:

- *Whilst there is recognition that it is essential for nurses and other workers in health and social care to be educationally prepared in order to be able to meet the needs of multicultural patient and client groups, there is little evidence of projects examining processes of problem-solving and learning in multicultural workforces.*

- *The contributions and challenges of such diverse workforces in health care for professional education, mentorship, preceptorship, practice education and clinical supervision have yet to be identified.*

INTERCULTURAL MENTORSHIP

Mentorship in the generic sense would appear to be a key mechanism to facilitate the adjustment and integration of overseas recruited health care staff into their role. However there would appear to be few studies of intercultural mentoring. Morales-Mann & Smith-Higuchi (1995) describe a study of Canadian mentor nurses and Chinese students in which cultural issues were found to have considerable impact on the mentorship relationship. For example each party shared different concepts of time, health, educational needs, customs and lifestyles. In a similar study Koskinen & Tossavainen (2003) describe Finnish nurses and British undergraduate nursing students during international placement experience in Finland. Strategies used to improve intercultural competence included mediating between the students and the Finnish culture in several ways. Koskinen & Tossavainen (2003) concluded that acting as an intercultural mentor was a complex and energy-consuming role, particularly given other clinical responsibilities. However it also provided opportunities for personal professional growth.

Summary point:

- *Intercultural working is a feature of health care workforces and intercultural mentoring is inevitably part of this. All mentoring takes time and effort but the evidence seems to indicate that intercultural mentoring involves additional commitment.*

THE NATURE OF CULTURE AND DIFFERENCE IN PRACTICE LEARNING

The concept of culture has been touched upon earlier and it is apparent that it can be defined and interpreted in many ways. It may be useful therefore to explore the discourse around the concept in order to develop an understanding that any definition of culture is grounded in a particular time, place and perspective. In relation to practice education, it may be helpful to think about culture as difference. Difference comes in many forms, but the most overt may be that of skin colour and language, ethnic background, cultural practices and nationality. It is this overt form of difference that is spoken about when, for example, referring to cultural diversity or multiculturalism.

Yet culture is not something uniform or homogenous. There is so much individual and inter-group difference and variation that it becomes difficult to box up and compartmentalise behaviours and practices. There is no essential culture. Rather, it is being enacted every day when people meet. It is being changed and re-invented, constructed and deconstructed as people talk, discuss, negotiate, and do things together. However, when we come into contact with people who are different in some obvious way, an approach to coping with this 'other-ness' may be to use cultural categories and generalisations.

There is a danger in conflating culture with ethnicity, in other words, using the word culture when we actually mean ethnicity or nationality, and the overt differences of ethnicity and nationality. The term 'difference' may be preferable because it immediately begs the question 'difference from what'? And it brings to our attention the fact that we as individuals make ourselves the yardstick for difference because the answer is always, of course, 'different from me' or 'different to what I am used to'. If we belong to a powerful group, say white, male, middle class, then we may also say 'different from me', and therefore 'different from what is normal or the norm'.

If we acknowledge difference, then we go beyond ethnicity and look at other ways of living life that may divert from what 'we' consider to be the norm. Some definitions of culture are not always helpful. They can be useful as stepping-stones in our thinking about how we may work and interact with others. However, culturally sensitive care, for example, may be represented exclusively as care that takes religious practices, and rules relating to food or social interaction into consideration. There is a danger of not moving beyond such a reductionist, tick-box type approach (Duffy 2001). Similarly, health care workers from different ethnic and cultural backgrounds may also be at risk from such stereotyping.

IMPLICATIONS FOR PRACTICE-BASED LEARNING IN HEALTH CARE

There has always been difference and cultural diversity within health care workforces in terms of, for example, social class, education, religious beliefs or sexual orientation. However, as a result of international recruitment and migration, they have recently come under renewed scrutiny. Difference in health care workforces may rise to the surface in relation to:

- Communication styles
- Attitudes towards conflict
- Approaches to tasks
- Decision-making and problem solving styles
- Attitudes towards disclosure about personal information and emotions
- Approaches to knowing
- Attitudes to authority
- Notions about accountability and responsibility
- Notions about the role of the family in the provision of healthcare

A consideration of learning in practice must begin with an understanding that these differences will have a profound impact on how students and professionals learn and work together, which in turn will ultimately determine the quality of care to patients. The term 'intercultural competence' seeks to describe the attitudes and skills that are necessary in order to function effectively and sensitively in multicultural environments irrespective of whether cultural differences exist between health care professionals, or between health care professionals and patients.

Drawing on the work of Bennett (1993) and Camphina-Bacote (1998, 1999), Koskinen (2003) defines intercultural competence as a

'learning process from lower to higher levels of self-awareness and personal maturation that moves through cognitive, affective and behavioural dimensions and leads to skills of increasing sensitivity toward other people'.

(Koskinen, 2003 p19).

The cognitive dimension of intercultural competence concerns our capacity to be flexible in our thought processes and to be able to move beyond the need to reduce new experiences to familiar and safe categories of understanding. The affective dimension relates to an emotional openness towards the unfamiliar, moving from an emotional response of threat and defensiveness to one of openness and willingness to engage. The behavioural dimension refers to the ability to express the mental and emotional adaptability described above into our interactions with others whose cultural background is unfamiliar to us (Gerrish et al 1996).

As economic interests within a growing service sector are producing an increasing number of international trade agreements, including a focus on health care, there will be a

corresponding increase in the mobility of health care professionals (Kingma 2001). Consequently, the need to prepare health care professionals in the UK to work with colleagues from different backgrounds, to act as their mentors or preceptors, or to support them as clinical supervisors for students will continue to grow. Therefore, intercultural competence will continue to be a pre-requisite skill for health care professionals. However, rather than relying on ad-hoc training sessions or individual aptitude and experience, the development of intercultural competence needs to be facilitated and nurtured both in pre-qualification education and in professional development.

Summary point:

- *Intercultural competence should be part of the skill set of all health practitioners and therefore evident in the work of practice educators. There is a need to understand the extent to which it features in practice educator preparation and more widely in education for placement.*

SUMMARY AND CONCLUSIONS

The aim of this literature review was to provide a brief critical overview of the issues involved in supporting practice learning. As a 'developmental project' rather than systematic research, it is primarily an appraisal of current issues. Some interpretation and conclusions have been drawn throughout and these were summarised in the 'summary points' at the end of each section. These are reproduced below.

THE NATURE AND EFFECTIVENESS OF PRACTICE EDUCATION

- For effective practice learning, practice educators should have the knowledge and skills to coach learners through triggering reflective learning periods on-the-job where there is a shared knowledge of the context and events
- In order to integrate theory and practice, practice educators need knowledge and skills in promoting reflective learning; have ability and authority to facilitate time and place for the learner to record their learning; and have insight into the knowledge provided within the academic curriculum

- Practice educators, who are in an obvious position of power vis-à-vis the learner, need to be aware not only of their performance as role models, but should also be sensitive to their influence on the professional socialisation of the learner.
- The continued exploration and critical appraisal of the effectiveness of different sequencing and patterns of placements along with proposed alternatives to the 1:1 model of practice educator support for health professions may provide innovative models for practice learning effectiveness in the future.
- Collaborative partnership systems between HEIs and health and placement providers that sustain and support the role and function of practice educators should be retained and continuously evaluated for their effectiveness.
- In auditing the learning environment and in providing any learning resources to support practice educators, the relative impact of team and organisational learning needs to be considered.

THE ROLE AND DEVELOPMENT OF THE EFFECTIVE PRACTICE EDUCATOR

- An effective practice educator needs good communication and interpersonal skills as well as practice proficiency and the ability to facilitate learning opportunities
- In order to value and formally recognise the importance of the practice educator role in facilitating and assessing practice learning within health care curricula, there is a need to have clearly defined competencies for practice educators to ensure effective practice education.
- To guarantee public protection, practice educator preparation courses should include the issues of accountability inherent in dealing with the 'failing' student
- Provision of courses and/or learning materials to develop and support the practice educator role need to be reviewed and evaluated for outcome effectiveness

INTERPROFESSIONAL LEARNING AND PRACTICE EDUCATION

- Opportunities for interprofessional learning in the practice setting are still being developed. Practice educators potentially play a key role in the organisation and facilitation of interprofessional practice based learning.
- Practice educator preparation programmes need to include specific learning opportunities to fulfil the specific requirements of facilitating interprofessional practice learning.

INTERCULTURAL ISSUES IN PRACTICE EDUCATION

- The contributions and challenges of diverse workforces in health care for professional education, mentorship, preceptorship, practice education and clinical supervision have yet to be identified.
- Intercultural working is a feature of health care workforces and intercultural mentoring is inevitably part of this. All mentoring takes time and effort but the evidence seems to indicate that intercultural mentoring involves additional commitment.
- Intercultural competence should be part of the skill set of all health practitioners and therefore evident in the work of practice educators. There is a need to understand the extent to which it features in practice educator preparation and more widely in education for placement.

Overall much of the literature is not research-based. Where empirical evidence is cited, it is generally based on uni-professional experience where studies are small and localised. This data whilst valuable in terms of the rich insight it offers, is not, however, generalisable. Nonetheless, this does not make these findings irrelevant, as research users will be able to judge transferability of findings to other settings. Large scale, countrywide or international comparative studies also have limitations but may facilitate comparisons between disciplines and geographical locations.

The function of the literature review in phase one the MPBLW project is essentially to provide a context for the findings from the discipline-specific case studies. These also include relevant literature as well as data collected specifically for the project. This stage will now be explored.

CASE STUDY METHOD

OVERALL DESIGN

Case study methodology (Yin 1994) underpinned the choice of data collection methods used to map the current nature of practice education in each of the project disciplines. A central aim of the case study was to obtain information on current practice in preparing practice based supervisors within five disciplines in both Great Britain and Ireland. The remit of the project precluded a formal research study and so the intent of phase one was to complete a 'scoping' exercise using the case study method. From this insights could be shared across disciplines and similarities and differences in practice education processes and roles determined in preparation for phase two of the project.

A case study approach to collecting information on a phenomenon has been used by a variety of disciplines, e.g. education (Hammersley 1986), experimental psychology (Yin 1994) and nursing (Woods 1998). They involve an in-depth examination of a particular phenomenon by focusing on relationships and processes within a natural setting. Stake (1994) believes differing definitions of the case study exist in the literature, with the consequence that the purpose and nature of case studies may vary considerably. Therefore, it is important to define and describe this case study so that the process of collecting information about a phenomenon is transparent.

DEFINITION

The project team selected the following two definitions of a case study to encapsulate the nature of the approach taken to examine current procedures used to prepare practitioners for the role of supervising students on practice placement within selected health care disciplines. The first definition for the term case study refers to the collection of detailed unstructured information collected from a range of sources about a particular group or institution, usually including the accounts of subjects themselves that does not attempt to generalise findings (Hammersley 1989).

This definition uses descriptive methods within a qualitative approach that matched the philosophical approach of the project team to the case study. However, this definition did not provide a clear guidance to data collection when the project team had commissioned teams to produce a case study for a specific health care discipline. The following definition

of the case study retained this philosophical approach, but also acknowledged a need to predetermine the data collection process:

- Coping with technically distinctive situations in which there are more variables of interest than data points.
- Relies on multiple sources of data, with data converging in a triangulating fashion.
- Benefits from prior development of theoretical propositions to guide data collection and analysis.

(Yin, 1994 p13)

The project team used these two definitions to undertake a case study that utilised analysis of the literature to guide data collection; collected information from a range of sources using different methods and triangulated data during data analysis. This then provided a description of the phenomenon of practice education within selected health care disciplines.

DATA COLLECTION PROCESS

The literature review for this report indicated the nature of information to be collected as the basis of the five separate case studies that were undertaken in the following disciplines; dietetics, nursing, occupational therapy, physiotherapy and radiography. The case study for each discipline was produced by a team of academics from that discipline, recruited by the project team. The teams consisted of a case study writer plus a number of contributors who assisted with collection and analysis of data. The Nursing, Occupational Therapy and Physiotherapy case study teams each had several contributors. However, because of size of the disciplines there was one contributor for Radiography and no contributors for Dietetics. Those case study teams with a writer and several contributors divided the distribution of institutions to be sampled into three geographical areas so that there would be a degree of equity in workload:

- Southern England
- Northern England
- Ireland, Scotland & Wales

The other two case study teams sampled the whole of Great Britain and Ireland collectively. The data collection methods used in all of the case studies were:

- Questionnaire
- Focus Group
- Secondary Data

QUESTIONNAIRE

A central aim of the case study was to obtain information on current practice in preparing practice based supervisors within five disciplines in both the Great Britain and Ireland. Limits in available time and resources for alternative data collection methods, such as individual interviews, meant that to collect data from such a large and geographically widespread sample, made use of a questionnaire the only feasible choice. Several influences, including the literature review and discussions amongst project and case study team members, informed questionnaire design. Information to be collected in the questionnaire included:

- Respondent, e.g. institution, discipline, course(s) with practice placement.
- Students, e.g. numbers by course and ethnicity, inter-professional learning, preparation for practice placement(s).
- Placement supervisors, e.g. criteria for appointment, preparatory courses, support mechanisms.
- Assessment of practice, e.g. methods, staff involvement.
- Benefits, problems and areas for development in practice based supervision.

To ensure that an overview of current practices plus a degree of depth of information of these practices could be obtained from a large diverse sample, the questionnaire consisted of a series of open and closed questions. A draft questionnaire was piloted by a convenience sample of six members of staff working in higher education with an interest in the preparation of practice based supervisors. Following revisions, the final version of the questionnaire (see Appendix One) was made available for completion in a number of ways:

- a. Accessed via the Internet, completed on-line and submitted as an e-mail to a named member of the project team.
- b. Accessed via the Internet, saved as a Word document, completed off-line and submitted as an e-mail attachment to a named member of the project team.
- c. Accessed via the Internet, saved as a Word document, printed out and completed, then submitted as a paper copy to a named member of the project team.

A letter containing information about the project and questionnaire completion instructions (appendix one), was sent to the Head of all Departments providing education in the five disciplines. These were identified in an analysis of relevant QAA subject discipline websites, professional and statutory body websites, plus informal knowledge held by members of both project and case study teams.

The number of questionnaire letters sent and returned by one of the three aforementioned methods for the five participating disciplines, after follow-up by either e-mail or telephone call, was:

DISCIPLINE	NUMBER SENT	NUMBER RETURNED	RESPONSE RATE (%)
Dietetics	13	6	46.2%
Nursing	86	19	23.8 %
Occupational Therapy	31	21	67.7%
Physiotherapy	37	21	56.8%
Radiography	26	12	46.2%
TOTAL	193	79	40.9%

FOCUS GROUPS

Focus groups were conducted at two regional workshops to gather detailed qualitative data on certain aspects of the phenomenon. Robinson (1999) defined focus groups as ‘an in-depth, open-ended group discussion that explores a specific set of issues on a pre-defined and limited topic.’ These staff self-selected participation by choosing to attend a workshop concerned with the preparation of practice supervisors. At the first workshop, four groups of approximately ten people were convened to discuss three questions:

1. What is good practice in preparation of practitioners for educating students on practice placement?
2. What factors influence the quality of practice education?
3. What materials could be developed to help make practitioners more effective practice educators?

Focus group participants completed a questionnaire (see Appendix Two) indicating their health care discipline plus their responses to the three questions above. These were then used to inform discussions that were facilitated by either a member of the project team or a

member of a case study writing team who had been briefed on the nature of the activity. Paper-based recordings of the discussions within each focus group were distributed to each case study team. Individuals' written answers to the three questions were distributed to the relevant case study team, determined by the respondents' discipline. A second workshop was held three weeks after the first workshop. A similar approach to the focus group was used, with two groups of ten participants meeting to first complete the questionnaire (Appendix Two).

SECONDARY DATA

Data that had been produced for another purpose was collected to provide contextual information about professional body perspectives on the preparation of practice educators and their role in supervision of students undertaking practice placements. This information was sourced from professional and statutory body reports and/or websites, e.g. Chartered Society of Physiotherapists, Health Professions Council, Nursing and Midwifery Council, Royal College of Nursing (Selected documents).

Whilst these documents give an overview of the standards expected by professional bodies associated, they often do not contain contextual information on the process and debates that may have informed their development. However, even with this caveat, such documents provide insight into professional expectations that can be compared with current practice through triangulation with both questionnaire and focus group data.

DATA ANALYSIS

GENERAL APPROACH

The various data collection methods used produced both qualitative and quantitative data. To facilitate analysis, data was merged by type, i.e. qualitative or quantitative, from all sources and analysed using the following approaches:

- ◆ Quantitative data from the closed questions from the questionnaire were analysed using the SPSS software package. Descriptive statistical analysis of the quantitative data involved frequency counts and percentages. Distribution of the demographic composition of the sample limited valid inferential statistical analysis of the data using the chi-squared test in what was essentially a descriptive approach to the case study.

- ◆ Qualitative data from the open questions from the questionnaire and the focus groups were printed out or copied as appropriate and collated by the relevant case study team. This data was analysed by following the principles of thematic analysis as described by Polit and Hungler (1995).

DEVELOPMENT OF THEMES

The case study writers used the data from all sources to develop their discipline-specific case study using a broad template provided by the project team. This was used to encourage a consistent approach and to facilitate subsequent comparisons between case studies. The project team undertook this latter process using the principles of thematic analysis and a number of categories of commonalities and differences began to emerge and these were recorded on spreadsheets. These included issues such as for example professional standards, length of programme, extent of practice educator preparation, content of course. In keeping with the intended outcome of phase one, the team then focused on identifying areas of good practice and innovation and inevitably issues of concern also emerged. It soon became evident that the data from the case studies fell into one or more of six broad themes. These will be discussed in more detail later.

LIMITATIONS

The case study approach was by no means comprehensive and the findings are therefore not generalisable. This was not the intent of the project team as this phase of the project was essentially seen as a scoping exercise. It was essentially a descriptive snapshot of the nature of practice education within each of the five professions from the perspective of 'insiders' on the ground who were able to describe their discipline and the current issues they faced. The opportunity to make comparisons between disciplines was however useful and highlighted a number of important issues.

None the less some limitations are worth noting. The questionnaire response for nursing was far less than expected and represented only 16.7% of the initially identified sample. There was no significant improvement in the response rate despite further telephone or e-mail contact. Of those who did respond, there was variation in the level of detail. Some for example gave only minimal information; however, in those cases one could criticise the questionnaire or some other aspect of the methodology. Whilst, it could be argued that

such a small response rate could go some way towards compromising the validity and reliability of the data as the number of non-respondents outnumbered the respondents, Bowling (2002) pointed out that an acceptable response rate is difficult to determine. Furthermore, Parahoo (1997) drew attention to the fact that those who did not respond may have had markedly different experiences or opinions than those who did respond.

Finally the focus group participants were self-selecting and recruited at regional workshops on practice-based learning. They may or may not therefore have reflected mainstream opinion.

OVERVIEW OF FINDINGS

The findings from the case study can be considered in two parts: first the discipline-specific case studies and second, findings from the cross-case study comparison.

DISCIPLINE-SPECIFIC CASE STUDIES

It is not possible within the limitations of the space of this occasional paper to reproduce the specific case studies in full. Each case study follows the same format and includes a glossary of terms; introduction; overview of practice education in the specific discipline; current nature of practice education in the specific discipline; discussion; summary and references. They can be accessed in full at the project web-site as follows: www.practicebasedlearning.org. By means of a summary, the abstracts of each case study are reproduced below.

DIETETICS

Dietetics is a relatively small profession but the growth in the numbers of dietitians to meet demand is limited by the availability of clinical placements. Pre-registration dietetics education and training includes both undergraduate and postgraduate courses. Courses are tightly regulated by the HPC but are going through a period of substantial change. In November 2000 the Dietitians Board of CPSM published changes in pre-registration training including the length of clinical placements and the learning outcomes of each placement block.

The Dietitians Board of CPSM and its successor the HPC have approved both HEI's and dietetics clinical placements. However, from July 2004, HEI's will be responsible for approving clinical placements in their regions using criteria to be set by the HPC. A BDA (British Dietetic Association) Placement Officer, funded by the HEI's, allocates clinical dietetic placements nationally. This process ensures that all placements are used efficiently and without the HEI's being required to double teach. From September 2005, the BDA will no longer support this activity so alternative arrangements for a national placement system are being discussed in the UDEG (University Dietetics Educational Group).

Dietetic facilitators, employed by the Workforce Development Confederation have successfully increased the number of hospitals training dietetics students, by supporting new trainers and providing supervisory skills training for dietetic staff often in conjunction with HEI's. There is still more work to be done by dietetic facilitators, as there is still a need for more placements. In dietetic departments who train students almost all staff are involved.

There are a number of recommendations that can be made as a result of the findings of the dietetics case study:

- Organised clinical supervisory skills courses must be available to all such dietitians and be credited for CPD.
- Clinical supervisory skills courses should be credited for CPD
- Training will need to be at two levels: basic supervisory skills for all staff; advanced supervisory skills for base (named) trainers.
- Provision must also be made for annual updating of staff.
- The Dietetic staff in HEI's together with the facilitators, need training and support in the delivery of these courses.

NURSING

This case study has provided an overview of the current standards for practice-based learning in pre-registration nursing programmes in the UK and the ROI. It has incorporated an outline of the ideal quality standards set by the regulatory bodies, the NMC and An Bord Altranais, and has presented the results from a national survey of HEI staff in all the countries of the UK and the ROI. Data from interprofessional focus groups has been assimilated into the results and the discussion.

Overall it may be observed that broadly similar approaches to practice based learning were adopted by all five countries. Practitioners providing direct patient/client care hold the key responsibility for facilitating practice learning and assessing the student as competent to register as a nurse. They are the 'gate-keepers' to the nursing profession.

Differences occurred between the ROI and the UK in the level and quantity of time spent by practitioners in receiving preparation for their roles as mentors/preceptors: two days preparation in ROI contrasting with the variable lengths of programmes on offer in the UK. However, each individual HEI in the UK had their own approach to content, level, length,

mode of delivery and audit. As a result, the mentorship experience for both mentors and their students varied from place to place. One could argue that this inconsistency leads to confusion and ambiguity and as a result mentorship and indeed practice based learning is compromised. Comparison with other professional groups is essential to set clear standards for the development of IPE preparation programmes that will support effective practice based learning.

New partnership practice education supporting roles are being instigated and developed primarily in NHS Trusts in the UK. Standards for the preparation, monitoring and development of these post-holders have been developed, but their positions and impact are in the early stages of being evaluated and at a policy level there is still no firm commitment to their ongoing funding. There are also similar support posts in the ROI that provide the link between the HEI and the health care agency. Comparison with the support frameworks provided to other professions taking part in this project is essential, in order to decide on the direction and outcomes of any innovations for these particular post holders.

Overall the commitment of staff and the organisations involved in the provision and support of practice education for nursing students is evident. It could be argued that whilst areas of good practice exist, these do so despite a number of structures that appear to work against the provision of well-supported, clearly supervised and adequately quality-assured practice education. Solutions to some of these problems are within the gift of the professional bodies, the HEI's and the placement providers to address and, indeed, some initiatives are evident. Others are related to inadequate funding and require political action from within the profession itself. Strength to implement change can be gained through working collaboratively with other health care professions in addressing the issues that are common to all; working out solutions; developing new ideas and; implementing and evaluating innovations.

From the nursing case study the following profession specific recommendations are suggested:

- Academic and professional accreditation for the status of the mentor/preceptor
- Recognition and acknowledgement of the demands of the role relative to patient/client workloads by employers
- Introduction of mentorship principles in the third year of pre-registration programmes to foster understanding

- Introduction of a developmental model to include grades of mentor, e.g. associate mentor to mentor to practice educator
- Standardisation and evaluation of preparation programmes at appropriate levels to suit an interprofessional practice education career framework
- Recognition of the need for partnership support roles such as the practice educator role and commitment to its continued development as part of a framework to support clinical academic careers.
- Continued clarification of practice education responsibilities for HEI's and placement providers

OCCUPATIONAL THERAPY

The findings from this case study reveal that there are many areas of good practice in occupational therapy, which are well established within the organisation and delivery of occupational therapy practice placements. Specific aspects of good practice have been identified which could be integrated into existing and new courses. However the study has also highlighted areas of possible development and improvement that could further build upon this good practice.

Practice educators enjoy and value their role in supervising and teaching students during their practice placements. They regard student supervision as a two-way process that informs and challenges their practice and facilitates them in reflecting upon their own clinical practice. Quality supervision is imperative during practice placements in order to facilitate the acquisition of professional competencies and enrich the quality of the placement experience. Within occupational therapy, students receive regular informal feedback about their performance plus the recommended one hour of formal supervision per week. This meets the requirements within both the College of Occupational Therapists' Standards for Education (2003) and the Revised Minimum Standards for the Education of Occupational Therapists (2002).

All higher education institutions providing occupational therapy education currently offer specific training courses to prepare practitioners to undertake the role of practice educator. However these courses vary in terms of content and length. Whilst there are many similarities regarding the topics covered on these courses, the findings of this study do not provide details about the actual material covered/taught on the courses so it can only be

presumed that a wide variation of content may exist. As identified within the literature, the practice educator plays a significant role in the professional practice placement experience; therefore it is essential that practice educators are well prepared for the supervisory role and the tasks associated with that role (Jones 1995).

Appropriate training should include:

- Information specific to the professional course.
- Teaching and learning styles/methods.
- Developing student learning contracts.
- Supervisory process.
- Mentoring.
- Reflective practice.
- Assessment.

Accreditation of occupational therapy services and individual practitioners is in place in many programmes. Variation exists regarding the requirements of each institution in order for individuals and services to achieve accreditation. Perhaps it would be beneficial to review the accreditation procedures with the intention of devising a standardised, formalised process across all occupational therapy programmes.

Many respondents to the survey highlighted several aspects of good practice regarding the support systems provided to both students and practice educators prior to and during placement periods indicating that effective partnerships are in place between the higher education institutions, the placement agencies and the students. Students are supported through the provision of placement handbooks, placement preparation workshops, prior visits to the placement sites and good induction programmes. Examples of useful support systems for the practice educators include regular meetings between the university practice placement tutors and the practice educators, placement visits, telephone and email contacts.

The importance of inter-professional learning is recognised within the occupational therapy profession and many programmes have integrated this philosophy into their programmes with the result that occupational therapy students are involved in shared learning with a wide range of student groups. Perhaps further exploration of the nature of this inter-professional learning would be beneficial.

Whilst the quality of student placements appears to be very high across the profession there are a number of areas that still require improvement. There is a presumption within the literature that practice educators are well supported by their colleagues, managers and agencies and are provided with the necessary training, resources and time to prepare for the role and that adjustments have been made to their workload to allow for their commitment to standard supervision (Ford & Jones, 1987). However, in reality, practice educators appear to be under considerable pressure to continue to manage heavy caseloads and at the same time provide high quality supervision for their students. There are no reductions in workloads with the result that staff sometimes have difficulty providing adequate time for formal supervision and frequently have to take student work home to check/mark.

There is also a lack of resources within some placement agencies in order to support student learning, for example, Internet access, desk space, library facilities and access to computers. It is widely recognised that placement experience is believed to have an influence on the professional development of students.

Therefore, it is essential that everyone involved in the provision of student placements including management/employers begins to acknowledge the crucial role of practice education and the factors involved in improving the quality standards of placement. Prior to the commencement of each placement, practice educators should be allowed time to prepare for the placement and subsequently during the placement their caseload should be reduced to allow adequate time to supervise and assess the student, thereby ensuring that the optimum learning environment is created. Emphasis must also be placed on the importance of making the placement environment conducive to student learning.

Inequity exists across regions within the UK in the payment of the Student Training Allowance with the result that some practitioners refuse to supervise students on placement if they are not going to be reimbursed for taking on the role and responsibilities.

From the occupational therapy case study the following recommendations can be made:

- There needs to be greater recognition, within placement agencies, of the role and responsibilities of being a practice educator. The role needs to be formally recognised with appropriate support provided by managers/employers in relation to time, resources and payment.

- Additional support systems should be put in place to support the practice educators in carrying out their role, for example:
 - Web CT package of learning resources/materials;
 - Professional development programme provided on an inter-professional basis;
 - Practice educators' support network/group;
 - Experienced practice educators acting as mentors to new practice educators;
 - Placement visits should be conducted to provide support to the practice educator as well as the student.
 - Placement coordinator posts – these often exist on a uni-professional basis but could be further developed to take on an inter-professional role in the future.
 - Creation of practice placement facilitator posts – although more work is required regarding the potential role of PPFs. There are currently different models of practice in place. These models need to be more formalised and standardised across the regions.
- A student learning resource room should be provided within the placement agency to facilitate greater inter-professional working and liaison between the student groups during practice placements. The room should have Internet access and could be used for joint tutorials. The provision of a facility like this would help to meet Standard P1.3 in enabling students and practice placement educators to have access to appropriate information resources such as the Internet, journals and publications held in both the HEI and the service setting. This would ensure that there is a range of resources and facilities to support independent learning and the facility would be welcomed by both students and practice placement educators.
- The process of accreditation of practice educators should be reviewed to ensure that the process is formalised and standardised across all of the occupational therapy programmes within the United Kingdom and Ireland. The College of Occupational Therapists is currently identifying a working group to undertake this project for implementation within the UK.
- Current assessment procedures for practice placements should be reviewed in an attempt to compile a nationally agreed assessment report for all occupational therapy practice placements. Further exploration and agreement is required as to whether students should be awarded a mark for their performance on placement

and whether these marks should contribute to the final classification of degree. There are arguments for and against their contribution to the overall degree classification. The main argument for their inclusion is to reflect the importance of learning in practice situations for preparing future practitioners. The argument against is the difficulty in standardising the marking system to ensure equity across a wide range of placement settings and individual practice educators. A standardised measurement instrument should be devised applying all the usual tests of validity and reliability to persuade all parties that assessment on placement is fair.

- Opportunities for greater inter-professional learning should be incorporated into the placement experience through the use of tutorials, visits, journal clubs, and meetings.
- Encouragement of greater liaison between the students on a daily basis and joint working on collaborative case studies would also be beneficial. This requires educational programmes to be re-organised so that placement times coincide across the professional groups.
- Alternative models of placement should be explored, encouraging greater uptake of the 2:1 model, 3:1 model, long arm supervision and the role emergent model. Greater use should be made of junior staff grades – Basic Grade therapists and technical instructors can make very valuable contributions to the education of students.

PHYSIOTHERAPY

This case study has been written at a time of professional body reflection on the nature of clinical education in physiotherapy and the accreditation of practice-based educators. Current debates centre around the growing pressure on an already stretched placement resource caused by increasing student numbers. Three main concerns have been highlighted: difficulties in obtaining specialist placements; models of clinical supervision where practice-based educators take on more than one student; and competition for placements in adjoining geographical areas. Various innovative solutions to these problems are being developed and tested in practice, such as using portfolios to provide evidence of specialist practice across placements; 2:1 models of student supervision; and collaboration between neighbouring HEIs to share placement resources.

The status and preparation of practice-based educators is currently under scrutiny and the newly launched ACE accreditation scheme offers opportunities for benchmarking standards and increasing the pool of qualified educators. The uptake of the scheme and the impact on practice-based education should be monitored and reviewed. HEIs and the practice environment face many challenges in providing appropriate learning experiences, particularly as physiotherapy moves increasingly towards primary care and inter-professional working. Many pre-registration physiotherapy courses are implementing classroom based inter-professional learning and, in some cases, this learning is extending into the clinical situation. Inter-professional student learning in practice will bring with it the need for focused preparation for educators, which could be tackled by multidisciplinary practice-based education models.

Many believe that practice based student education should be the responsibility of all physiotherapists, in order to safeguard the future of the profession. However, it remains at the discretion of individual Trusts, managers and clinicians whether or not to provide placements. Payment for taking students remains a highly contentious issue and disparities regarding financial remuneration need to be tackled in order to bring equity and consistency, and to safeguard the future of clinical education. Support in its widest sense appears to be the central factor in securing placement availability and attracting clinicians into practice-based education.

A number of recommendations can be made regarding the physiotherapy case study:

- Managers, HEIs and the multidisciplinary team should feature as key players in supporting practice-based educators
- There should be recognition of the importance of student education
- Equity and consistency in student payments need to be addressed
- There should be reward/regard for the practice educator role
- Workplace issues such as dedicated time for students and increased staffing levels are issues that need to be tackled.
- Developments of current innovations should be monitored and extended, e.g. 2:1 model of supervision, collaboration between HEI's in the allocation of placements, use of portfolios
- The new accreditation scheme for practice educators needs to be monitored and reviewed

- Multi-disciplinary models of practice based education should be developed

RADIOGRAPHY

The College of Radiographers supports the premise of widening participation and increasing flexible delivery of radiography courses and also promotes continuing professional development and life-long learning for all practitioners in radiography. This is evidenced by the piloting of the career progression framework in selected clinical centres and also by the publication of a number of strategy and guidance documents for its implementation. The development of the more flexible workforce, in the four-tier structure, is ultimately to improve patient services and to provide faster and more accessible care. To facilitate the developing workforce, programmes of education that have flexible entry and exit points and part time attendance are being pursued by a number of HEIs. The implementation of any changes in the present education and training arrangements should only be undertaken with close collaboration between the professional practice service providers, the College of Radiographers, higher education institutions, workforce development confederations, Health Professions Council and other relevant agencies.

What effect the introduction of the assistant practitioner role will have on pre-registration student radiographers has yet to be evaluated. Assistant practitioners will be paid as they undertake a training programme and will be given the opportunity to progress into professional level education. This will lead to an anomaly in the payment between assistant practitioners and pre-registration radiography students, which in turn may lead to some degree of friction between the groups. It was suggested that student radiographers should receive some method of payment when undertaking periods of professional practice and this may merit further investigation.

As education providers continue to increase student numbers to meet NHS workforce targets additional pressure is placed on the capacity of professional practice placements and the workload of practice educators. The fact that all practice educators felt that they did not have enough time to devote to their role as educators, and having additional students added to the stress they experienced, is of concern. Therefore, it becomes imperative that there is appropriate investment in both the human and physical resources necessary to support professional practice education.

There are a number of recommendations that can be made from the radiography case study:

- HEIs should actively seek additional and innovative opportunities for professional practice education in an effort to relieve the pressure on existing centres. Professional practice education in radiography has traditionally occurred in clinical centres: perhaps there is the possibility of developing professional practice education opportunities in non-traditional areas.
- More use should be made of professional practice teaching suites where students could gain practical skills using role-play scenarios. This would be beneficial before placement to introduce the students to new skills and to reinforce students learning after a period of placement.
- Clinical departments and HEIs need to collaborate to maximise the use of facilities for the attainment of professional practice skills. More flexible use of the available professional practice places should be investigated.
- Documentation from the HEI should be clear and unambiguous. Regular information/study days should be held to inform clinical staff and clarify any particular areas.
- Professional practice educators should be allowed sufficient time, be fully supported and have access to the appropriate education and training necessary for them to fulfil their vital educational role in the preparation of the future workforce.
- Attendance at an appropriate training course should be compulsory for practice educators before they undertake the education and assessment of students.
- In order to retain the expertise of experienced practice educators they need to be given recognition for the valuable role that they fulfil in the education and development of the future workforce. The opportunity for career progression that is available to clinical specialists should be equally available to practice educators.
- Inter-professional education in practice environments should be encouraged not solely for the benefits that it brings for students and practice educators but ultimately because of the benefits it brings for the patients.
- Investment in resources for practice education should encompass personnel to support course delivery in academic and practice settings, as well as physical resources. A particular area that requires considerable investment is the provision of adequate IT facilities to support the growth of web-based support for students and practice educators.

- If the four tier structure is judged to be the appropriate way forward to enable the radiography profession to deliver a modern radiography service, then all stakeholders need to work in partnership to facilitate its implementation and to ensure protection of the public.

CROSS-CASE STUDY COMPARISONS

From the analysis of each case study, comparisons were made and a number of commonalities and differences emerged with regard to the nature of practice education and the preparation of the practice educator.

COMMONALITIES

- All professions have statutory requirements regarding the nature of work-based learning within the curriculum.
- All students are prepared for placement experiences.
- All professions report to being under-resourced in terms of time, staff, and availability of placements.
- All professional groups are required to function within the inter-professional learning and working environment.
- Inter-professional learning is curriculum rather than work-based.
- All practice educators are prepared but content, length and level of preparation vary across and within professions and do not necessarily have a statutory agreement.
- No formal career pathway for practice educators exists within the professions.
- All practice educators are involved in formative assessment and some in summative assessment.
- Learning needs of practice educators are similar across the professions.

DIFFERENCES

- Management, organisation and location of placements within the curriculum and between disciplines.
- Methods used to determine placement quality and standards.
- Titles, roles and responsibilities given to the practice educator.

- Criteria for becoming a practice educator.
- Recognition, accreditation and standing of the practice educator and method of reward differ within and between professional groups.
- Volume of students; student to practice educator ratios; and models of working with students
- Supervision and assessment of work based learning by practice educators.
- Nature of preparation of practice educator - length, contents, monitoring.
- Support for practice educators is varied and reported to be insufficient in some instances.
- Divergence in student funding and reimbursement for work based learning.
- Multicultural issues were not fully explored

EMERGENCE OF SIX KEY THEMES

In addition, areas of good practice, innovation and issues of concern were extracted from the case study data and these were grouped into six broad themes:

- Learning and Teaching in Practice
- Support for Learning in Practice
- Reflection in Practice
- Assessment in Practice
- Interprofessional Learning in Practice
- Diversity in Practice

Examples of good practice and innovations within each of these six themes are now summarised:

TEACHING AND LEARNING IN PRACTICE

Examples of good practice include:

- Centrality of placements: The centrality of practice placements to the professional competence of the student is regarded as positive by all case study writers with professional practice in some cases being 50% of the course curriculum.
- Standards: All the case study writers commented positively on the standards relating to

practice based learning. All five disciplines have regulatory standards regarding practice based learning. These are written and issued by the relevant professional bodies and meet QAA requirements on practice based learning. The nature of these standards varies in relation to detail and enforcement, which was highlighted as a problem for practice based learning.

- Preparation of practice educators: The preparation of practice educators was also described positively, with all five disciplines providing preparatory courses for practice educators. The preparatory training provided for practice educators varied between different Higher Education Institutions and across the different disciplines. The courses offered ranged from 0.5 day to a number of days leading to a university accredited module.
- Preparation of students: The standard of preparation and support of students was commented on by all case study writers as good. Students in all five disciplines received preparation and support. This appeared to be the area where most work has been done by HEIs. Student support varied between HEIs from telephone contact and visits to web based on line support.

Some innovations in this area include:

- Interprofessional preparatory courses: There were examples where preparatory courses have been developed between professions although this was rare, e.g. joint courses between physiotherapists and occupational therapists and this was viewed as a very favourable development.
- Portfolios for students: The development of the students professional practice portfolio was highlighted by a number of disciplines as a positive development.

SUPPORTING TEACHING AND LEARNING IN PRACTICE

Examples of good practice include:

- Dedicated practice placement staff: In a number of the disciplines there is currently a dedicated person funded by the HEIs or WDC who develops new placement opportunities and who may in some cases allocate the placements centrally.
- IT Developments: Use of email, WebCT and Blackboard to support practice educators
- Communication: Meetings to allow practice educators to raise issues

Some innovations in this area include:

- Centralisation of resources: The organisation of placements again varied. In some

cases there was a co-ordinated approach to the distribution of placements. In physiotherapy, a central database in the South of England has been developed to maximise the utilisation of available placements between a number of HEIs.

REFLECTION IN AND ON PRACTICE

Examples of good practice include:

- Student portfolios: The development of the use of portfolios for students as a means of reflection was highlighted as good practice by all disciplines.

Some innovations in this area include:

- Online portfolios: The development of online portfolios was highlighted as an area of good practice within radiography
- Range of models of supervision: The use of 2:1 supervision was stated by physiotherapy as a positive development that allows for greater reflection through discussion among peers.

ASSESSMENT IN PRACTICE

Examples of good practice include:

- Role of practice educator in assessment: The role of the practice educator in assessment was stated as a positive development. In a number of the case studies the practice educator had a summative role in the assessment of the students.

Some innovations in this area include:

- Shared assessment tools: A shared assessment tool was highlighted as good practice within physiotherapy.

INTERPROFESSIONAL LEARNING IN PRACTICE

Examples of good practice include:

- Interprofessional learning as part of curricula: All disciplines included interprofessional learning as part of the curricula and this was agreed to be good practice by all the disciplines.

Some innovations in this area include:

- Interprofessional preparatory courses for practice educators: Examples of training for

practice educators from different disciplines were given as illustrative of innovative practice within occupational therapy and physiotherapy.

DIVERSITY IN PRACTICE

Examples of good practice include:

- Quality of placements: The quality of placements was highlighted in a number of the case studies as the key means by which students were given the opportunity to gain experience in working with diversity.

Some innovations in this area include:

- Practice placements: It was stated that there were innovative practices taking place in practice based learning but that there was a lack of formal evidence of these to include within the case studies.

CONCLUSIONS AND RECOMMENDATIONS FOR PHASE TWO

REVISITING THE AIMS OF THE PROJECT

To recap, the Making Practice Based Learning Work (MPBLW) project aims to make practitioners more effective at supporting and supervising students in the workplace across a range of healthcare disciplines namely Dietetics, Nursing, Occupational Therapy, Physiotherapy and Radiology. The outcome for Phase One was to 'identify and document good practice on how practitioners are prepared for their educational role'. This paper has shown how the project team used the vehicle of a case study to scope each of the disciplines to determine the nature of practice education in each profession. Comparisons were made to determine commonalities, differences, areas of good practice and innovation, as well as issues for concern. From this analysis six themes were identified as central to the effectiveness of preparing practitioners for their role as practice educators. These themes have been mapped against the Nursing and Midwifery Council Standards (NMC 2002a) and Health Professions Council (HPC 2004) -see Appendix Three.

However a number of areas of concern also emerged from the case study data and confirm some similar issues raised in the literature review. The issue that was most commented on by all the disciplines was the need for recognition of the role of practice educator. A number of case study writers believed that there needed to be more formal and accredited training for practice educators. They felt that there needed to be an element of progression within this training to raise the value of the role of practice educator. The accreditation of these courses and CPD recognition by professional bodies and employers would greatly improve the status of the role of practice educator.

The number of placements available was also a central concern raised by all case study writers, although all stated this should not be the case if all those eligible to be practice educators were active in this role. In nursing this was due to the demand for the number of placements, whereas in occupational therapy this was due to an inexplicable lack of available practice educators. Linked to this was the lack of time available to fulfil the role effectively and therefore areas such as reflective practice was difficult to facilitate as there was insufficient time for practice educators to reflect on their own practice.

There were some frustrating issues related to assessment such as a lack of clarity in documentation. In addition a number of the case studies stated that the weighting of

practice based learning in the assessment process needed to be increased. Practice based learning was mainly accredited as pass or fail and was not given appropriate recognition in the formal assessment process of many professional courses.

Reflecting the literature, the integration of interprofessional learning into practice was logistically problematic. Interprofessional learning is a new requirement for the five healthcare disciplines. Integration of interprofessional learning in the workplace was stated as an aspect that is not happening to any great extent. All case study writers stated that the bulk of interprofessional learning took place within the Higher Education Institution and that to extend this to the workplace, remained logistically challenging to organise.

The area of diversity as stated earlier was poorly covered by the case study but none the less some issues emerged. For example, the need to address diversity by increasing accessibility with regards to increasing numbers entering the five professions from currently under represented groups was promoted in principle by Higher Education Institutions. However, in practice this is not happening. Cultural diversity was stated in all case studies as a government target, yet in practice all case study writers presented data indicating that the majority being educated in the five participating discipline professions were predominately white and female. The numbers of students with a disability were not always available to enable the case study writers to make conclusions on this matter.

In conclusion although there was a lot of variation in the organisation of practice placements there is a central issue for all five healthcare disciplines, this being the need to improve the status of the role of practice educator. There is an increasing demand for quality placements and for this demand to be met practice educators need to be prepared and supported to carry out this role effectively.

RECOMMENDATIONS FOR PHASE TWO

The completion of phase one of MPBLW has revealed some important insights into the nature of the preparation of practice educators in five healthcare disciplines. In phase two of the project, the team is required to:

- Develop and evaluate learning materials for use by practitioners across five healthcare disciplines.
- Make learning materials available in a number of efficient media, e.g. paper, electronic, CD-ROM and web-based.

- Develop a programme applicable to interprofessional and uniprofessional contexts.
- Widen access for a multicultural workforce.

As the third point illustrates, the project team intended to develop a cross-curricular practice educator preparation programme. However the case study indicates that differing professional standards and requirements would make this difficult to achieve and embed. Instead, responding to data from the case study, phase two (June 2004 – May 2005) has involved developing a freely-accessible web-portal of learning materials for use by practice educators in curriculum design and delivery. Working with representatives from across the disciplines, the six themes from phase one have been used to group learning resources within this portal and a search facility will be provided. The utility and effectiveness of the learning resources will be evaluated during phase three of the project.

In addition, following completion of phase one the team is developing its practice educator database in order to help develop the web-portal around the six themes and seek feedback on relevance and utility. Learning resources related to the key themes are being commissioned and these will be developed with an interprofessional focus. Professional bodies, CAIPE and the Higher Education Academy Subject Networks will be approached to disseminate issues of concern and to promote the learning resources for interprofessional use.

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APPENDIX ONE: Letter and Postal Questionnaire

Dear

As the key person in placement provision you have been approached as the individual in your institution most able to provide information about practice placements in a specific discipline.

The practice placement experience of health care students is key to successful education and training of the health care workforce. This Funding Development in Teaching and Learning (FDTL4) project, funded by Higher Education Funding Council England (HEFCE) and the Department of Employment and Learning (DEL) Northern Ireland aims to help educators/mentors become more effective at supporting and supervising students in the workplace across the following range of healthcare disciplines:

Nursing
Physiotherapy
Occupational Therapy
Radiography
Dietetics

The project will develop generic materials to support practice placement educators/mentors taking healthcare students for their pre-registration practice placements. Prior to developing these materials, we need your views as to what is required. Your experience in this area will form an essential component of this project. For further information you are invited to access the project website. <http://www.practicebasedlearning.org/quest.htm>

The aims of the this report include:

- a. Auditing the university based preparation of practitioners for their educational role in supporting students during practice placements.
- b. Identifying principles of good practice that emerge from the audit.

We would be grateful if you would complete the audit on behalf of your HEI.

You can complete the audit online at <http://www.practicebasedlearning.org> and submit is directly to the Audit administrator, Chris Turnock.

Alternatively, you can save the document and either:

-complete and save as a word document, which can be emailed to chris.turnock@unn.ac.uk

- print the document and post a completed printed version to
Chris Turnock
H216
Main Building
Northumbria University

Please complete separate audits for each discipline if you are reporting on more than one discipline.

We have a team working on writing the final report for this project and the member of the team working in your discipline will contact you to talk through any issues you may have

in/when completing the audit. As a result of completing the questionnaire you will receive a copy of this report and you will be kept informed of developments resulting from the project.

All data will be stored on password-protected computers and will be treated as confidential.

In addition, we are interested in highlighting and sharing good practice in this area. We would be grateful if you would identify any aspects of your institution's approach to practice based learning that exemplifies good practice and/or innovation.

Yours sincerely

J. Mullholland
Project Director

ALL COMPLETED AUDITS RECEIVED BY 13/10/03 WILL BE ENTERED IN A DRAW
FOR £100 BOOK TOKEN

PRACTICE-BASED LEARNING AUDIT

SECTION A: Institutional Data

1. Institution details

Name of institution	
Website details for your courses	

2. Your Contact details

Name	
Telephone	
Email	
Address	
Can we approach you for further information?	Yes/No

3. Discipline, tick as appropriate

Discipline	(√)
Nursing	
Physiotherapy	
Dietetics	
Occupational therapy	
Radiography	

4. Pre-registration courses offered which include practice placements, (Eg Pre Reg Diploma or BSc etc)

a. Undergraduate Pre-registration courses
1.
2.
3.
b. Postgraduate pre-registration courses
1.

2.
3.

Section B Student Information

5. Please indicate, if possible, the total number and gender of students that enrolled on the first year of your 2002 pre-registration undergraduate and postgraduate course(s)

a. Pre-registration Undergraduate Course	Number	Male	Female
1.			
2.			
3.			
b. Pre-registration Post-graduate Course	Number	Male	Female
1.			
2.			
3.			

6. Please indicate, if possible, the number students with disabilities for the 2002 undergraduate pre-registration intake

a. Undergraduate Course 2002	Physical Disability	Learning Disability
1.		
2.		
3.		
b. Postgraduate Course 2002		
1.		
2.		
3.		

7. Please indicate, if possible, the ethnic breakdown of students by number on your undergraduate and post-graduate pre-registration course(s)

	UG No.1	UG No.1	UG No. 3	PG No. 1	PG No.2	PG No.3
White						
Black African						
Black Carribean						
Black other						
Indian						
Pakistani						
Bangladeshi						
Chinese						
Asian other						
Other						

8a. Do your undergraduate students and /or postgraduate pre-registration students experience any interprofessional education within the university? Yes/No

If yes please give details:

Where	
When	
Topics covered	
With what professions	

8b. If no, please indicate why not:

Comment

8c. Do all pre-registration students receive the same preparation prior to practice placement?

Yes/No/Not applicable

If yes please answer question 8d.

If No please answer question 8d. in relation to preparation of students for the course which has the greatest number of students.

8d. What preparation do students receive prior to practice placement:

Preparation	
Preparatory Workshops	
Handbook	
Web based material	
Prior Visit	
Induction at workplace	
Other	

Section C Roles and Responsibilities

9. Does your university have someone with specific responsibility for managing the links between the University and clinical placements?

YES/NO

10. What criteria does the university set with regards to the qualifications and experience mentors/educators must have for mentoring/educating students on practice placement?

Criteria: please list

11. To your knowledge are any practice based staff specifically allocated to fulltime practice placement support?

YES/NO

Section D: Preparation of clinical educators/mentors

12a. What courses do you offer to prepare clinical practice mentors/educators for their role, where are these courses held and are credits included for these courses?

Course	Where Please specify	Credits included (Yes/No)	Accreditation Please specify
1.			
2.			
3.			
4.			
5.			

12b. Is there CPD recognition for attendance at these courses?

YES/NO

12c. Is attendance compulsory on an annual basis before a student is allocated?

YES/NO

13. In the academic year 2002-2003 how many mentors/educators attended these courses

Course	Total
1	
2	
3	
4	
5	

14. Please list who teaches on these courses

Course	Teachers/trainers
1.	
2.	
3.	
4.	
5.	

15a). Please tick what is covered in the courses offered by your HEI?

	Course 1	Course 2	Course 3	Course 4	Course 5
Roles, responsibilities and accountability					
Programme planning					
Learning Contracts					
Setting student tasks					
Portfolios					
Monitoring students progress					
Student Assessment					
Student Absence					
Mentor/educator absence					
Insurance issues					
Communication skills					
Coaching skills					
Counseling skills					
Teaching styles					
Learning styles					
Assignment writing					
Reflective practice					
Special needs					
Cultural diversity					
Report writing					
Mentoring					
Facilitation					
Discipline					
Confidentiality and ethics					
Legal requirements					
Consent					
Rules and Regulations					
Health Professions Council					

15b. Would you be happy to provide examples of materials covering the above?

YES/NO

15c. If your institution has any standards for clinical placements which includes mentor preparation could you please send them to us?

YES/NO

15d. Have there been any developments or innovations with regards to how you deliver these courses?

YES/NO

Comment

16a. Are there any ongoing support mechanisms for practice educators/mentors?

(EG meetings, Blackboard, WebCT, telephone contact)

YES/NO

Comment

16b. Have there been any developments in the support mechanisms for practice educators/mentors?

YES/NO

Comment

Section F: Assessment

17a. Please indicate which of the following assessment methods are used to assess student competence on any of your pre-registration practice placements?

Method	Yes / No
Portfolio	
Observation of professional practice	
Recording and reporting	
Written reports	
Reflective records	
Case Studies	
Peer discussion	
Oral presentation	
Other (please specify):	

17b. Has there been developments in methods used to assess competence?

YES/NO

Comment

18. Please tick which of the following staff are involved in the formative and/or summative assessment process for any of your pre-registration courses.

Staff involved	Formative (ongoing)	Summative (Final)
Manager or deputy		
Named practice supervisor		
Senior clinicians as group		
HEI Placement tutor		
Other (specify)		

Section G Concluding comments

(please continue on a separate sheet if required)

19. List up to 3 benefits work based supervisors have highlighted regarding their experience of supervising students on practice placement

1.

2.

3.

20. List up to 3 problems that practice-based supervisors bring to your attention regarding the supervision of students on practice placement

1.

2.

3.

21. In an ideal world, what measures would help to address these problems?
Please list in order of priority

1.

2.

3.

22. Are there any comments you would like to make regarding the support of mentors/educators that you have not covered in the audit?

Thank you for completing this questionnaire

APPENDIX TWO: Focus Group Questionnaire

Please right down your answers to the following questions. They will be used to inform the workshop discussions. We would also like to collect the answers at the end of the conference as your answers may be used in case studies on the nature of practice education in health care.

INSTITUTION:

DISCIPLINE:

What is good practice in preparation of practitioners for educating students on practice placement?

What factors influence the quality of practice education?

What materials could be developed to help make practitioners more effective practice educators?

APPENDIX THREE: Mapping of key themes against professional body standards.

MAPPING OF PROFESSIONAL STANDARDS AGAINST AREAS FOR TENDER								
NMC Advisory Standards for Mentors & Mentorship (Nursing and Midwifery Council 2002a pages 10 & 11)								
	Communication & Working Relationships	Facilitation of Learning	Assessment	Role Modelling	Creating an Environment for Learning	Improving Practice	Knowledge Base	Course Development
Learning & Teaching in Practice	X	X		X	X		X	
Supporting Learning in Practice	X	X		X	X		X	
Reflection in Practice	X			X		X		
Interprofessional Work in Practice	X			X		X	X	
Diversity in Practice				X		X		
Assessment in Practice			X	X				

MAPPING OF PROFESSIONAL STANDARDS continued						
HPC Practice Placement Standards (Health Professions Council 2004 page 7)						
	Preparation of Practice Educators	Relevant qualification, experience and training	Collaboration with HEI	Provision of Information	Learning & Teaching Methods	Equal Opportunities
Learning & Teaching in Practice	X				X	
Supporting Learning in Practice		X	X	X		
Reflection in Practice					X	
Interprofessional Work in Practice						
Diversity in Practice						X
Assessment in Practice	X					